

Petition by:

Iowa Association of Oriental Medicine and Acupuncture
for a Declaratory Order by the
Iowa Board of Physical Therapy and Occupational Therapy
to define Dry Needling/Intramuscular Manual Therapy as a form of
Acupuncture and not within the legal scope of practice of
Physical Therapy and Occupational Therapy

Presented August 17, 2015

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Petition for Declaratory Order on
Dry Needling / Intramuscular Manual Therapy

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1. There are persons in Iowa who are utilizing acupuncture needles by performing a technique called "Dry Needling" or "Intramuscular Manual Therapy" in violation of:
 - 1.1.1. Iowa Code 148. Practice of Medicine and Surgery
 - 1.1.2. Iowa Code 148E. Practice of Acupuncture,
 - 1.1.3. Iowa Code 148A.1 Physical Therapy,
 - 1.1.4. FDA Title 21, Section 880.5580 Acupuncture Needle, and
 - 1.1.5. FDA Title 21, Section 880.109 Prescription Devices
- 1.2. The most common violation is by Physical Therapists and Athletic Trainers.
- 1.3. They are being trained by non-accredited "Dry-Needling/Intramuscular Manual Therapy" training programs that falsely advertise the legality of dry-needling by non-acupuncturists.
- 1.4. One such program, Kinetacore states that the Iowa Board of Physical and Occupational Therapy ruled in June 2012:

"It has been the consensus of the Board that dry needling does not appear to be prohibited by the law or administrative rules. However, dry needling is an advanced skill that requires additional training beyond entry-level education and should only be performed by PTs who have completed additional education and demonstrated knowledge, skill, ability and competency in the performance of the procedure. If the Board determines that a PT is performing dry needling outside their training or expertise it could result in the licensee being disciplined by the Board. The Board has not issued an official opinion or policy statement on the performance of dry needling by Iowa licensed PTs."
- 1.5. Searches of the Minutes and official declarations of the Iowa Board of Physical and Occupational Therapy does not reveal the above declaration.
- 1.6. There have been informal discussions about Dry Needling at recent Iowa Board of PTOT meetings. They have specifically resisted the need to create a formal ruling.
- 1.7. There has been no known public discussion on dry needling by the Iowa Board of Athletic Training.
- 1.8. The use of acupuncture needles is the practice of acupuncture.
- 1.9. The act of puncturing the skin is within the scope of the practice of medicine and prohibited unless allowed by statutory authority, such as that allowed to acupuncturists in Iowa Code 148E. Practice of Acupuncture.
- 1.10. The use of the term "Intramuscular Manual Therapy" refers to the use of "manual" therapy, not the use of an acupuncture needle. This rebranding of the use of acupuncture needles as a "Manual" therapy is designed to bypass the licenses of

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acupuncture and to avoid the need to use the rarely reimbursed insurance codes for acupuncture.

- 1.11. The use of the term "Dry Needling" is a rebranding of the use of acupuncture needles through the false claim that it is solely a Western Medical therapy and has no relation to the practice of acupuncture. The origins of western medicine using acupuncture needles for trigger point therapy began with Injections of pharmaceuticals into the trigger points in the 1960s. Injection therapy is an invasive and dangerous procedure.
Dry Needling is just as invasive and dangerous. The advanced technique of "lifting/thrusting" is a documented acupuncture technique with centuries of use. Dry Needling uses this technique. It should be reserved for advanced acupuncture practitioners.
- 1.12. The use of "trigger points" for therapy have been documented for over 1,400 years. They are defined as "ashi" or tender points.
- 1.13. There are no statutory definitions of "dry needling" and "intramuscular manual therapy" in the Physical Therapy license Chapter 148A.1
- 1.14. There is no statutory authorization to insert any object into a patient, nor to use acupuncture needles in the Physical Therapy license Chapter 148A.1
- 1.15. Acupuncture needles are not mechanical devices, they are medical devices, subject to the following FDA restrictions:
 - 1.15.1. Labeling for single use only and conformance to the requirements for prescription devices set out in 21 CFR 801.109,
 - 1.15.2. A device which, because of any potentiality for harmful effect, or the method of its use, or the collateral measures necessary to its use is not safe except under the supervision of a practitioner licensed by law to direct the use of such device, and hence for which "adequate directions for use" cannot be prepared.
- 1.16. There is specific code in Chapter 201.1(2) that should prohibit the use of "dry needling" and acupuncture needles by Physical Therapist due to the prohibition on practicing "outside the scope of the license."

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2. Citations and Statutes:

2.1. 148E.1 Acupuncture Definitions.

- 2.1.1. "Acupuncture" means a form of health care developed from traditional and modern oriental medical concepts that employs oriental medical diagnosis and treatment, and adjunctive therapies and diagnostic techniques, for the promotion, maintenance, and restoration of health and the prevention of disease.
- 2.1.2. "Acupuncturist" means a person who is engaged in the practice of acupuncture.
- 2.1.3. "Practice of acupuncture" means the insertion of acupuncture needles and the application of moxibustion to specific areas of the human body based upon oriental medical diagnosis as a primary mode of therapy. Adjunctive therapies within the scope of acupuncture may include manual, mechanical, thermal, electrical, and electromagnetic treatment, and the recommendation of dietary guidelines and therapeutic exercise based on traditional oriental medicine concepts.

2.2.152D.1 Athletic Trainer Definitions.

- 2.2.1. "Athletic trainer" means a person licensed under this chapter to practice athletic training under the direction of a licensed physician.
- 2.2.2. "Athletic training" means the practice of prevention, recognition, assessment, physical evaluation, management, treatment, disposition, and physical reconditioning of athletic injuries that are within the professional preparation and education of a licensed athletic trainer and under the direction of a licensed physician. The term "athletic training" includes the organization and administration of educational programs and athletic facilities, and the education and counseling of the public on matters relating to athletic training.

2.3.148A.1 Physical Therapy Definitions — referral — authorization.

- 2.3.1. 148A 1(b) As used in this chapter, "physical therapy" is that branch of science that deals with the evaluation and treatment of human capabilities and impairments. Physical therapy uses the effective properties of physical agents including, but not limited to, mechanical devices, heat, cold, air, light, water,

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electricity, and sound, and therapeutic exercises, and rehabilitative procedures to prevent, correct, minimize, or alleviate a physical impairment.

2.3.2. 148A 1(c) Physical therapy includes the interpretation of performances, tests, and measurements, the establishment and modification of physical therapy programs, treatment planning, consultative services, instructions to the patients, and the administration and supervision attendant to physical therapy facilities.

2.3.3. 148A.1.2. Physical therapy evaluation and treatment may be rendered by a physical therapist with or without a referral from a physician, podiatric physician, dentist, or chiropractor, except that a hospital may require that physical therapy evaluation and treatment provided in the hospital shall be done only upon prior review by and authorization of a member of the hospital's medical staff.

2.4. 148B.2 Occupational Therapy Definitions:

2.4.1. 148B2.3. "*Occupational therapy*" means the therapeutic use of occupations, including everyday life activities with individuals, groups, populations, or organizations to support participation, performance, and function in roles and situations in home, school, workplace, community, and other settings. Occupational therapy services are provided for habilitation, rehabilitation, and the promotion of health and wellness to those who have or are at risk for developing an illness, injury, disease, disorder, condition, impairment, disability, activity limitation, or participation restriction. Occupational therapy addresses the physical, cognitive, psychosocial, sensory-perceptual, and other aspects of performance in a variety of contexts and environments to support engagement in occupations that affect physical and mental health, well-being, and quality of life. "*Occupational therapy*" includes but is not limited to providing assessment, design, fabrication, application, and fitting of selected orthotic devices and training in the use of prosthetic devices.

2.5. FDA Title 21 Section 880.5580 Acupuncture needle.

2.5.1.1.(a) *Identification*. An acupuncture needle is a device intended to pierce the skin in the practice of acupuncture. The device consists of a solid, stainless steel needle. The device may have a handle attached to the needle to facilitate the delivery of acupuncture treatment.

(b) *Classification*. Class II (special controls). Acupuncture needles must comply with the following special controls:

1) Labeling for single use only and conformance to the requirements for

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prescription devices set out in 21 CFR 801.109, FDA Section 801.109

Prescription Devices

2.6. FDA Title 21 Section 801.109 Medical Devices.

A device which, because of any potentiality for harmful effect, or the method of its use, or the collateral measures necessary to its use is not safe except under the supervision of a practitioner licensed by law to direct the use of such device, and hence for which "adequate directions for use" cannot be prepared, shall be exempt from section 502(f)(1) of the act if all the following conditions are met:

(a) The device is:

(1)(i) In the possession of a person, or his agents or employees, regularly and lawfully engaged in the manufacture, transportation, storage, or wholesale or retail distribution of such device; or

(ii) In the possession of a practitioner, such as physicians, dentists, and veterinarians, licensed by law to use or order the use of such device; and

(2) Is to be sold only to or on the prescription or other order of such practitioner for use in the course of his professional practice.

(b) The label of the device, other than surgical instruments, bears:

(1) The statement "Caution: Federal law restricts this device to sale by or on the order of a _____", the blank to be filled with the word "physician", "dentist", "veterinarian", or with the descriptive designation of any other practitioner licensed by the law of the State in which he practices to use or order the use of the device; and

(2) The method of its application or use.

(c) Labeling on or within the package from which the device is to be dispensed bears information for use, including indications, effects, routes, methods, and frequency and duration of administration, and any relevant hazards, contraindications, side effects, and precautions under which practitioners licensed by law to administer the device can use the device safely and for the purpose for which it is intended, including all purposes for which it is advertised or represented: *Provided, however,* That such information may be omitted from the dispensing package if, but only if, the article is a device for which directions, hazards, warnings, and other information are commonly known to practitioners licensed by law to use the device. Upon written request, stating reasonable grounds therefor, the Commissioner will offer an opinion

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on a proposal to omit such information from the dispensing package under this proviso.

- 2.7. There are no FDA definitions of "Dry Needling Needle" nor "Intramuscular Manual Therapy needle". All other needle definitions are categorized as medical devices.

3. Questions to be answered:

- 3.1. What are the medical and legal definitions of "trigger points", "Ashi point", "intramuscular manual therapy", "dry needling" and "lifting/thrusting technique"?
- 3.2. Does the use of "trigger points" equate to the use of "Ashi" points?
- 3.3. Is Dry Needling/Intramuscular Manual Therapy a technique within the practice of acupuncture due to the utilization of a FDA regulated medical device, the acupuncture needle?
- 3.4. Is Dry Needling/Intramuscular Manual Therapy an invasive technique?
- 3.5. What type of training should be required?
- 3.6. How is the safety of the patient protected?
- 3.7. Who should be legally able to perform dry needling/intramuscular manual therapy?

4. Answers:

4.1. Definitions:

- 4.1.1. "Trigger points" are areas of myofascial tissue that exhibit pain and tension upon palpation. This modern name is synonymous in anatomy and historical medical use with "Ashi points."
- 4.1.2. "Ashi Point" is an acupuncture point that exhibits tenderness and is located through palpation of soft tissue (myofascial tissue). Many Ashi points are located in the belly of skeletal muscles, and are identical in anatomy and function as "trigger points." Ashi points have been studied and used by traditional acupuncture for 1,400 years ago.
- 4.1.3. "Intramuscular Manual Therapy (IMT)" is used in Physical Therapy as synonymous to "Dry Needling," the name given to a technique used to penetrate the skin and into muscle with an acupuncture needle to activate a trigger point. However, it is a Physical Therapy term and is used to avoid the use of the term "needle" and circumvent the definitions of "acupuncture", "needle" and "insertion,"

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This is due to the fact that Physical Therapy is not licensed to use acupuncture needles, nor to penetrate the skin.

- 4.1.3.1. "Intramuscular" means "within muscle."
- 4.1.3.2. "Manual" refers to the use of hands.
- 4.1.3.3. Literally this should mean "hands within muscle." By these definitions it is not apparent that a needle is used, nor that there is penetration into the body.
- 4.1.4. "Dry Needling (DN)" has its western origins in the study of myofascial pain by a Medical Doctor, Janet Travell, MD, who described "trigger points" in bio-medical terms. She began a therapy called, "Point Injections" (later referred to as "Wet Needling") where trigger points were injected with saline or medicine. After decades of study and influence by acupuncturists, Medical Doctor practitioners of Point Injections began to experiment with solid, filiform needles instead of injections. They found the therapy reduced musculoskeletal pain. "Dry Needling" was the term used to describe this technique due to the lack of injectable medicine. The most common "dry needle" technique used in activating a trigger point is called "lifting/thrusting," a technique learned from acupuncture.
- 4.1.5. "Lifting/thrusting" is an acupuncture technique whereby the needle is inserted into the belly of a muscle and subsequently lifted partially out and thrust back into the muscle multiple times, often causing the muscle to spasm.
 - 4.1.5.1. It is a very advanced needle technique due to the deep insertion into muscle and the kinetic motion of the needle.
 - 4.1.5.2. Thin needles can bend and break when used in "lifting/thrusting".
 - 4.1.5.3. In certain cases, the muscles can spasm and trap the needle in the muscle fibers.
 - 4.1.5.4. Caution and experience are needed to safely remove needles if broken or trapped.
 - 4.1.5.5. The technique can be very painful and can result in the "shock" of the patient.
 - 4.1.5.6. Lifting/Thrusting has been practiced by acupuncturists for centuries.
- 4.1.6. **According to the history and practice of acupuncture, "Dry Needling" and "Intramuscular Manual Therapy" are styles and subsets of acupuncture with both modern and ancient therapeutic precedents.**

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- 4.2. **The western biomedical definition of “trigger point” is identical to the ancient acupuncture point definition of an “Ashi point”.** The modern definition of “trigger point” is considered a bio-mechanical definition of “Ashi point” as taught in nationally accredited acupuncture programs.
- 4.3. Dry Needling/Intramuscular Manual Therapy uses “solid filiform” needles.
- 4.3.1. There are no FDA nor Iowa code definitions of “Dry Needling/IMT needles.”
- 4.3.2. There is a FDA definition of acupuncture needle as a “solid filiform needle”, with restrictions on use.
- 4.3.3. Therefore, **Dry Needling/IMT utilizes acupuncture needles.**
- 4.3.4. The use of acupuncture needles is restricted by the FDA to professions who are licensed and trained in the practice of acupuncture.
- 4.3.5. Therefore, **Dry Needling/IMT is a style and subset of acupuncture.**
- 4.3.5.1. Not all of acupuncture is dry needling, but all of dry needling is acupuncture.
- 4.4. **Dry Needling/Intramuscular Manual Therapy is an invasive medical procedure, as is acupuncture.**
- 4.4.1. The “lifting/thrusting” needle technique used in DN/IMT is dangerous due to the deep penetration of the acupuncture needle into muscles and body tissue.
- 4.4.2. There are many trigger points that are adjacent to internal organs, large blood vessels and nerves.
- 4.4.3. The extensive list of potential adverse effects includes:
- 4.4.3.1. Minor: bruising, bleeding, pain following treatment.
- 4.4.3.2. Significant: Prolonged pain at site, extensive bruising, profuse sweating, vomiting, headache, fainting, skin irritation, slurred speech, seizure.
- 4.4.3.3. Serious: pneumothorax, puncture of other vital organ, systemic infection, broken needle.
- 4.5. **Extensive clinical observation and supervision is required to practice “lifting/thrusting” or Dry Needling/IMT safely.**
- 4.5.1. In nationally certified acupuncture training programs it is taught only to advanced acupuncture students or post-graduate acupuncturists. There are no accredited acupuncture training programs that allow newly trained students to learn this

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advanced technique. If taught to acupuncture students it is taught in the final year of a four year program.

4.5.1.1. In contrast, non-accredited, non-acupuncture DN/IMT training programs allow un-trained persons to begin using "lifting/thrusting" with acupuncture needles after a few hours of lecture and observation. The entire training program can be as little as 24 hours.

4.5.1.1.1. These new trainees receive a certificate of completion and are then told to practice at least 200 treatments prior to returning for the next 24 hour training session. There is no supervision by an experienced DN/IMT professional outside of the short training courses.

4.5.2. DN/IMT is an invasive medical procedure that requires extensive graduate level education in an accredited acupuncture training program.

4.6. The safety of DN/IMT patients must be of the highest priority.

4.6.1. Nationally accredited acupuncture programs have extensive education in needle precautions and contraindications.

4.6.1.1. In contrast, non-accredited non-acupuncture DN/IMT training programs have only a few hours of education in needle safety.

4.6.1.2. Prior to any clinical observation or practice with acupuncture needles, acupuncture students must take and pass an 8 hours education course entitled, "Clean Needle Technique". Thereafter, for the four years of acupuncture education, this information is consistently commented and expanded on by instructors and many course exams place emphasis on needle safety.

4.6.2. In acupuncture training, many hundreds of hours are spent in accredited institutions learning individual point locations along with safe needling depth and angles.

4.6.2.1. In contrast, non-accredited non-acupuncture DN/IMT training programs cover entire muscle groups/regions in less than 90 minutes. This time includes trigger point anatomy, clinical observation and practice. There can be many muscles and many dozen trigger points included in each of these muscle groups.

4.6.3. In acupuncture, many hundreds of hours are spent in accredited institutions in observation and clinical supervision on the use of acupuncture needles.

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- 4.6.3.1. In contrast, non-accredited non-acupuncture DN/IMT have a few hours of observation and supervision and then are encouraged to practice unsupervised for at least 200 treatments until they receive further education.
- 4.6.4.. An extensive national certification examination is required to practice acupuncture. The written and practical sections related to safety in use of acupuncture needles are a substantial portion of the testing.
- 4.6.4.1. In contrast, non-accredited non-acupuncture DN/IMT training programs have a simple non-accredited written and practical exam at the end of the 24 hour training course. There is no national nor professional standard for this examination.
- 4.6.5. In order to maintain certification in acupuncture, 60 credits of continuing education are required every 4 years. 4 or more of those hours must be in safety and ethics.
- 4.6.5.1. In contrast, non-accredited non-acupuncture DN/IMT training programs have no requirements for continuing education. Furthermore, Physical Therapists who practice DN/IMT are not required to have any DN/IMT continuing education.
- 4.7. In relation to all of the logic and documentation above and presented in the supplemental materials with this petition, the proper formal declaration by the Iowa Board of Physical Therapy and Occupational Therapy should be:
 - 4.7.1. **In order to legally and safely practice Dry Needling/Intramuscular Manual Therapy, one must be licensed to practice acupuncture or be exempt from the statutes of the practice of acupuncture.**

- 5. Reasons for request of declaratory order by the Iowa Association of Oriental Medicine and Acupuncture:
 - 5.1. Due to the incidence of minimally trained persons practicing acupuncture through the re-labeling of acupuncture as "Dry Needling/IMT", the Iowa Board of Physical Therapy and Occupational Therapy needs to make a declaratory order to formally define "dry needling" and "intramuscular manual therapy" and formally prohibit its


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licensees, Physical Therapists and Occupational Therapists, from utilizing this technique.

- 5.2. The use of acupuncture needles as taught and practiced in Dry Needling/IMT is an advanced and dangerous technique. It is taught to advanced acupuncturists in graduate level nationally accredited training programs. It is impossible to prevent injury to patients when persons are allowed to use this technique after short training programs and unsupervised practice.
 - 5.3. The current lack of a definition and clarification of the scope of DN/IMT places the public at physical and financial risk by allowing non-acupuncturists to practice. Nationally, there have been confirmed cases of muscle and nerve damage and pneumothorax due to DN/IMT by non-acupuncturists.
6. There are no known formal declarations nor statutes on the definition and scope of DN/IMT.
- 6.1. The Iowa Board of Physical and Occupational Therapy has chosen not to create a formal ruling.
 - 6.2. The Iowa Association of Oriental Medicine and Acupuncture is petitioning the Iowa Board of Physical and Occupational Therapy to formally declare that "Dry Needling" and "Intramuscular Manual Therapy" is not in the scope of practice of Physical Therapists nor Occupation Therapists.
 - 6.3. The Iowa Board of Physical Therapy and Occupational Therapy should formally petition the following boards to concur with this ruling and issue their own prohibitions on the use of Dry Needling and Intramuscular Manual Therapy by their licensees:
 - 6.3.1. Iowa Board of Athletic Trainers
 - 6.3.2. Iowa Board of Massage Therapists
 - 6.3.3. Iowa Board of Physician Assistants
 - 6.3.4. Iowa Board of Nursing
 - 6.3.5. Iowa State Board of Health

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7. This declaratory order would affect all professions who have been practicing acupuncture, and those who have been practicing Dry Needling/Intramuscular Manual Therapy, such as Physical Therapists, Athletic Trainers, Medical Doctors, Doctors of Osteopathy and Chiropractors. It is possible that Advanced Registered Nurse Practitioners, Massage Therapists, Physician Assistants and others are also performing Dry Needling/Intramuscular Manual Therapy, but our association is not aware of such.
8. Our Association would request to be present in all meetings held by the Iowa Board of Physical Therapy and Occupational Therapy in regard to this Declaratory Order.
9. This petition is formally introduced by a board member of the Iowa Association of Oriental Medicine and Acupuncture (IAOMA), William Terrell, Licensed Acupuncturist, Diplomate of NCCAOM, Master of Science in Oriental Medicine. The address of IAOMA and Mr. Terrell is: Iowa Acupuncture Clinic, 8230 Hickman Road, Suite B, Clive, Iowa 50325. Phone contact: 515-331-8948. Email: IAOMAonline@gmail.com

Signed: 

William Terrell, L.Ac. Dipl NCCAOM, MSOM
Board of Iowa Association of Oriental Medicine and Acupuncture

653—1.9(17A) Declaratory orders.

1.9(1) *Petition for declaratory order.* Any person may file a petition with the board of medicine for a declaratory order as to the applicability to specified circumstances of a statute, rule, or order within the primary jurisdiction of the board. A petition is deemed filed when it is received by the board office. The board shall provide the petitioner with a file-stamped copy of the petition if the petitioner provides the board office with an extra copy for this purpose. The petition must be typewritten or legibly handwritten in ink and must substantially conform to the following form:

BOARD OF MEDICINE

Petition by (Name of Petitioner) for a Declaratory Order on (Cite provisions of law involved). }

PETITION FOR DECLARATORY ORDER

The petition must provide the following information:

1. A clear and concise statement of all relevant facts on which the order is requested.
2. A citation and the relevant language of the specific statutes, rules, policies, decisions, or orders, whose applicability is questioned, and any other relevant law.
3. The questions petitioner wants answered, stated clearly and concisely.
4. The answers to the questions desired by the petitioner and a summary of the reasons urged by the petitioner in support of those answers.
5. The reasons for requesting the declaratory order and disclosure of the petitioner's interest in the outcome.
6. A statement indicating whether the petitioner is currently a party to another proceeding involving the questions at issue and whether, to the petitioner's knowledge, those questions have been decided by, are pending determination by, or are under investigation by, any governmental entity.
7. The names and addresses of other persons, or a description of any class of persons, known by petitioner to be affected by, or interested in, the questions presented in the petition.
8. Any request by petitioner for a meeting provided for by 1.9(7). Ch 1, p.6 Medicine[653] IAC 10/8/08

The petition must be dated and signed by the petitioner or the petitioner's representative. It must also include the name, mailing address, and telephone number of the petitioner and petitioner's representative, and a statement indicating the person to whom communications concerning the petition should be directed.

1.9(2) *Notice of petition.* Within 15 days after receipt of a petition for a declaratory order, the board shall give notice of the petition to all persons not served by the petitioner

pursuant to 1.9(6) "c" to whom notice is required by any provision of law. The board may also give notice to any other persons.

1.9(3) Intervention.

a. Persons who qualify under any applicable provision of law as an intervenor and who file a petition for intervention within 20 days of the filing of a petition for declaratory order shall be allowed to intervene in a proceeding for a declaratory order.

b. Any person who files a petition for intervention at any time prior to the issuance of an order may be allowed to intervene in a proceeding for a declaratory order at the discretion of the board.

c. A petition for intervention shall be filed with the executive director at the board office. Such a petition is deemed filed when it is received by that office. The board will provide the petitioner with a file-stamped copy of the petition for intervention if the petitioner provides an extra copy for this purpose.

A petition for intervention must be typewritten or legibly handwritten in ink and must substantially conform to the following form:

BOARD OF MEDICINE

Petition by (Name of Original Petitioner) for a Declaratory Order on (Cite provisions of law cited in original petition). }

PETITION FOR INTERVENTION

The petition for intervention must provide the following information:

1. Facts supporting the intervenor's standing and qualifications for intervention.
2. The answers urged by the intervenor to the question or questions presented and a summary of the reasons urged in support of those answers.
3. Reasons for requesting intervention and disclosure of the intervenor's interest in the outcome.
4. A statement indicating whether the intervenor is currently a party to any proceeding involving the questions at issue and whether, to the intervenor's knowledge, those questions have been decided by, are pending determination by, or are under investigation by, any governmental entity.
5. The names and addresses of any additional persons, or a description of any additional class of persons, known by the intervenor to be affected by, or interested in, the questions presented.
6. Whether the intervenor consents to be bound by the determination of the matters presented in the declaratory order proceeding.

The petition must be dated and signed by the intervenor or the intervenor's representative. It must also include the name, mailing address, and telephone number of

the intervenor and intervenor's representative, and a statement indicating the person to whom communications should be directed.

1.9(4) Briefs. The petitioner or any intervenor may file a brief in support of the position urged.

The board may request a brief from the petitioner, any intervenor, or any other person concerning the questions raised.

1.9(5) Inquiries. Inquiries concerning the status of a declaratory order proceeding may be made to the executive director at the board office.

1.9(6) Service and filing of petitions and other papers.

a. When service required. Except where otherwise provided by law, every petition for declaratory order, petition for intervention, brief, or other paper filed in a proceeding for a declaratory order shall be served upon each of the parties of record to the proceeding, and on all other persons identified in the petition for declaratory order or petition for intervention as affected by or interested in the questions presented, simultaneously with their filing. The party filing a document is responsible for service on all parties and other affected or interested persons. IAC 10/8/08 Medicine[653] Ch 1, p.7

b. Filing—when required. All petitions for declaratory orders, petitions for intervention, briefs, or other papers in a proceeding for a declaratory order shall be filed with the executive director at the board office. All petitions, briefs, or other papers that are required to be served upon a party shall be filed simultaneously with the board.

c. Method of service, time of filing, and proof of mailing. Method of service, time of filing, and proof of mailing shall be as provided by 653—25.11(17A).

1.9(7) Consideration. Upon request by petitioner, the board must schedule a brief and informal meeting between the original petitioner, all intervenors, and the board, a member of the board, or a member of the staff of the board, to discuss the questions raised. The board may solicit comments from any person on the questions raised. Also, comments on the questions raised may be submitted to the board by any person.

1.9(8) Action on petition.

a. Within the time allowed by Iowa Code section 17A.9(5), after receipt of a petition for a declaratory order, the board shall take action on the petition as required by Iowa Code section 17A.9(5).

b. The date of issuance of an order or of a refusal to issue an order is as defined in 653—subrule 25.11(4).

1.9(9) Refusal to issue order.

a. The board shall not issue a declaratory order where prohibited by Iowa Code section 17A.9(1) and may refuse to issue a declaratory order on some or all questions raised for the following reasons:

(1) The petition does not substantially comply with the required form.

(2) The petition does not contain facts sufficient to demonstrate that the petitioner will be aggrieved or adversely affected by the failure of the board to issue an order.

- (3) The board does not have jurisdiction over the questions presented in the petition.
- (4) The questions presented by the petition are also presented in a current rule making, contested case, or other agency or judicial proceeding, that may definitively resolve them.
- (5) The questions presented by the petition would more properly be resolved in a different type of proceeding or by another body with jurisdiction over the matter.
- (6) The facts or questions presented in the petition are unclear, overbroad, insufficient, or otherwise inappropriate as a basis upon which to issue an order.
- (7) There is no need to issue an order because the questions raised in the petition have been settled due to a change in circumstances.
- (8) The petition is not based upon facts calculated to aid in the planning of future conduct but is, instead, based solely upon prior conduct in an effort to establish the effect of that conduct or to challenge an agency decision already made.
- (9) The petition requests a declaratory order that would necessarily determine the legal rights, duties, or responsibilities of other persons who have not joined in the petition, intervened separately, or filed a similar petition and whose position on the questions presented may fairly be presumed to be adverse to that of petitioner.
- (10) The petitioner requests the board to determine whether a statute is unconstitutional on its face.

b. A refusal to issue a declaratory order must indicate the specific grounds for the refusal and constitutes final agency action on the petition.

c. Refusal to issue a declaratory order pursuant to this provision does not preclude the filing of a new petition that seeks to eliminate the grounds for the refusal to issue an order.

1.9(10) Contents of declaratory order—effective date. In addition to the order itself, a declaratory order must contain the date of its issuance, the name of petitioner and all intervenors, the specific statutes, rules, policies, decisions, or orders involved, the particular facts upon which it is based, and the reasons for its conclusion. A declaratory order is effective on the date of issuance.

1.9(11) Copies of orders. A copy of all orders issued in response to a petition for a declaratory order shall be mailed promptly to the original petitioner and all intervenors.

1.9(12) Effect of a declaratory order. A declaratory order has the same status and binding effect as a final order issued in a contested case proceeding. It is binding on the board, the petitioner, and any intervenors who consent to be bound and is applicable only in circumstances where the relevant facts Ch 1, p.8 Medicine[653] IAC 10/8/08 and the law involved are indistinguishable from those on which the order was based. As to all other persons, a declaratory order serves only as precedent and is not binding on the board of medicine. The issuance of a declaratory order constitutes final agency action on the petition.

These rules are intended to implement Iowa Code chapters 17A, 21, 68B, 148, 148E, 252J, 261, and 272C.

17A.9 DECLARATORY ORDERS.

1. *a.* Any person may petition an agency for a declaratory order as to the applicability to specified circumstances of a statute, rule, or order within the primary jurisdiction of the agency.

b. (1) An agency shall issue a declaratory order in response to a petition for that order unless the agency determines that issuance of the order under the circumstances would be contrary to a rule adopted in accordance with subsection 2.

(2) However, an agency shall not issue a declaratory order that would substantially prejudice the rights of a person who would be a necessary party and who does not consent in writing to the determination of the matter by a declaratory order proceeding.

2. Each agency shall adopt rules that provide for the form, contents, and filing of petitions for declaratory orders, the procedural rights of persons in relation to the petitions, and the disposition of the petitions. The rules must describe the classes of circumstances in which the agency will not issue a declaratory order and must be consistent with the public interest and with the general policy of this chapter to facilitate and encourage agency issuance of reliable advice.

3. Within fifteen days after receipt of a petition for a declaratory order, an agency shall give notice of the petition to all persons to whom notice is required by any provision of law and may give notice to any other persons.

4. Persons who qualify under any applicable provision of law as an intervenor and who file timely petitions for intervention according to agency rules may intervene in proceedings for declaratory orders. The provisions of sections 17A.10 through 17A.18 apply to agency proceedings for declaratory orders only to the extent an agency so provides by rule or order.

5. Within thirty days after receipt of a petition for a declaratory order, an agency, in writing, shall do one of the following:

a. Issue an order declaring the applicability of the statute, rule, or order in question to the specified circumstances.

b. Set the matter for specified proceedings.

c. Agree to issue a declaratory order by a specified time.

d. Decline to issue a declaratory order, stating the reasons for its action.

Iowa Administrative Code

6. A copy of all orders issued in response to a petition for a declaratory order must be mailed promptly to the petitioner and any other parties.

7. A declaratory order has the same status and binding effect as any final order issued in a contested case proceeding. A declaratory order must contain the names of all parties to the proceeding on which it is based, the particular facts on which it is based, and the reasons for its conclusion.

8. If an agency has not issued a declaratory order within sixty days after receipt of a petition therefor, or such later time as agreed by the parties, the petition is deemed to have been denied. Once a petition for a declaratory order is deemed denied or if the agency declines to issue a declaratory order pursuant to subsection 5, paragraph "d", a party to that proceeding may either seek judicial review or await further agency action with respect to its petition for a declaratory order.

Organizations Affected by Dry Needling Declaratory Order

State Boards

1. Iowa Board of Physical Therapy & Occupational Therapy
321 E. 12th Street, Des Moines, Iowa 50319
515.281.0254
Email: jmanning@idph.state.ia.us
Contact: Judy Manning, Board Administrator
2. Iowa Board of Medicine
400 SW 8th Street, Des Moines, IA 50309
515.281.7088
Email: mark.bowden@iowa.gov
Contact: Mark Bowden, Executive Director
3. Iowa Board of Chiropractic
321 E. 12th Street, Des Moines, IA 50319
515.281.0254 *Same as PTOT
Email: khoover@idph.state.ia.us
Contact: Karla Hoover, Office Secretary
4. Iowa Board of Podiatry
321 E. 12th Street, Des Moines, IA 50319
515.281.0254 *Same as PTOT
Email: Tony.Alden@idph.iowa.gov
Contact: Tony Alden, Board Executive *same as IA Board of Athletic Training
5. Iowa Dental Board
400 SW 8th Street, Suite D, Des Moines, IA 50309
515.281.5157
Fax: 515.281.7969
Email: idb@iowa.gov
6. Iowa Board of Nursing
400 SW 8th Street, Des Moines, Iowa 50309
515.281.3255
Fax: 515.281.4825
Email: ibon@iowa.gov
7. Iowa State Board of Health
321 E. 12th Street, Des Moines, Iowa 50319
515.281.8474 *Same as PTOT
Email: gerd.clabaugh@idph.iowa.gov
Contact: Gerd Clabaugh, Board Administrator

Organizations Affected by Dry Needling Declaratory Order

8. Iowa Board of Athletic Training
321 E. 12th Street, Des Moines, Iowa 50319
515.281.0254 *Same as PTOT
Email: tony.alden@idph.iowa.gov
Contact: Tony Alden, Board Administrator *Same as IA Board of Podiatry
9. Iowa Board of Massage Therapy
321 E. 12th Street, Des Moines, Iowa 50319
515.281.0254 *Same as PTOT
Email: pierce.wilson@idph.iowa.gov
Contact: Pierce Wilson, Board Administrator *Same as IA Board of Physician Assistants
10. Iowa Board of Physician Assistants
321 E. 12th Street, Des Moines, Iowa 50319
515.281.0254 *Same as PTOT
Email: pierce.wilson@idph.iowa.gov
Contact: Pierce Wilson, Board Administrator *Same as IA Board of Massage Therapy

Professional Organizations

1. Iowa Physical Therapy Association & Foundation
521 East Locust Street, suite 202, Des Moines, Iowa 50309
515.222.9838
Email: natalie@capturemarketinggroup.com
Contact: Natalie Battles
2. Iowa Chiropractic Society
1255 SW Prairie Trail Parkway, Ankeny, IA 50023
515.867.2800
Email: director@iowadcs.org
Contact: Molly Lopez, Executive Director
3. Iowa Medical Society
515 E. Locust Street, Suite 400, Des Moines, IA 50309
515.223.1401
Fax: 515. 223. 0590
Email: ckelly@iowamedical.org
Contact: Clare Kelly, Executive Vice President

Organizations Affected by Dry Needling Declaratory Order

4. Iowa Osteopathic Medical Association
950 12th Street, Des Moines, IA 50309
515.283.0002
Email: leah@ioma.org
Contact: Leah McWilliams, Executive Director
5. Iowa Hospital Association
100 E. Grand Ave, Des Moines, IA 50309
515.288.1955
Email: norrisk@ihaonline.org
Contact: Kirk Norris, President and CEO
6. Iowa Nurses Association
2400 86th Street, #32 Urbandale, IA 50322
515.225.0495
Email: info@iowanurses.org
7. Iowa Podiatric Medical Society
6919 Vista Dr, West Des Moines, IA 50266
515.282.8192
Fax: 515.282.9117
Email: ipms@ipms.org
Contact: Kevin Kruse, Executive Director
8. Iowa Dental Association
8797 NW 54th Ave, Suite 100, Johnston, IA 50131
Mailing Address: PO Box 31088, Johnston, IA 50131-9478
515.331.2298
Fax: 515.334.8007
Email: info@iowadental.org
9. Iowa Physician Assistant Society *Same info as Iowa Podiatric Medical Society
6919 Vista Drive, West Des Moines, IA 50266
515.282.8192
Fax: 515.282.9117
10. Iowa Chapter of the American Massage Therapy Association
Email: amtaiowa@gmail.com

Organizations Affected by Dry Needling Declaratory Order

Accredited Physical Therapy Educational Programs

1. Des Moines University - Doctoral of Physical Therapy degree
3200 Grand Avenue, Des Moines, Iowa 50312
PT Admission Office: 800.241.2767, ext. 1499
DMU Office: 515.271.1400
Email: info@dmu.edu or PTadmit@dmu.edu
2. University of Iowa Carver College of Medicine
Department of Physical Therapy and Rehabilitation
1-252 Medical Education Building
Iowa City, IA 52242
Email: Richard-shields@uiowa.edu
Contact: Richard Shields, PT, PhD, FAPTA, Executive Chair of the Department

Non-Accredited Training Programs

1. KinetaCore
563 PO Box, Brighton, CO 80601
877.573.7036
Fax 720.247.9131
2. Integrative Dry Needling Institute
7051 Navajo Trail, Solon, Ohio 44139
404.594.4221
Email: info@integrativedryneedling.com
3. Dr. Ma Dry Needling Course
3 Wildwood Lane, Boulder, CO 80304
303.516.0595
Email: ma@dryneedlingcourse.com

National Acupuncture Certification Organization

1. NCCAOM- National Certification Commission for Acupuncture and Oriental Medicine
76 South Laura Steet, Suite 1290, Jacksonville, FL 32202
904.598.1005
Fax: 904.598.5001

CHAPTER 206
LICENSURE OF OCCUPATIONAL THERAPISTS
AND OCCUPATIONAL THERAPY ASSISTANTS

[Prior to 3/6/02, see 645—201.3(147,148B,272C) to 645—201.7(147) and 645—201.9(272C)]

645—206.1(147) Definitions. For purposes of these rules, the following definitions shall apply:

“Active license” means a license that is current and has not expired.

“Board” means the board of physical and occupational therapy.

“Department” means the department of public health.

“Grace period” means the 30-day period following expiration of a license when the license is still considered to be active. In order to renew a license during the grace period, a licensee is required to pay a late fee.

“Inactive license” means a license that has expired because it was not renewed by the end of the grace period. The category of “inactive license” may include licenses formerly known as lapsed, inactive, delinquent, closed, or retired.

“Licensee” means any person licensed to practice as an occupational therapist or occupational therapy assistant in the state of Iowa.

“License expiration date” means the fifteenth day of the birth month every two years after initial licensure.

“Licensure by endorsement” means the issuance of an Iowa license to practice occupational therapy to an applicant who is or has been licensed in another state.

“Licensure examination” means the examination administered by the National Board for Certification in Occupational Therapy.

“Mandatory training” means training on identifying and reporting child abuse or dependent adult abuse required of occupational therapists or occupational therapy assistants who are mandatory reporters. The full requirements on mandatory reporting of child abuse and the training requirements are found in Iowa Code section 232.69. The full requirements on mandatory reporting of dependent adult abuse and the training requirements are found in Iowa Code section 235B.16.

“NBCOT” means the National Board for Certification in Occupational Therapy.

“Occupational therapist” means a person licensed under this chapter to practice occupational therapy.

“Occupational therapy assistant” means a person licensed under this chapter to assist in the practice of occupational therapy.

“Occupational therapy practice” means the therapeutic use of occupations, including everyday life activities with individuals, groups, populations, or organizations, to support participation, performance, and function in roles and situations in home, school, workplace, community, and other settings. Occupational therapy services are provided for habilitation, rehabilitation, and the promotion of health and wellness to those who have or are at risk for developing an illness, injury, disease, disorder, condition, impairment, disability, activity limitation, or participation restriction. Occupational therapy addresses the physical, cognitive, psychosocial, sensory-perceptual, and other aspects of performance in a variety of contexts and environments to support engagement in occupations that affect physical and mental health, well-being, and quality of life. The practice of occupational therapy includes:

1. Evaluation of factors affecting activities of daily living (ADL), instrumental activities of daily living (IADL), rest and sleep, education, work, play, leisure, and social participation, including:

- Client factors, including body functions (such as neuromusculoskeletal, sensory-perceptual, visual, mental, cognitive, and pain factors) and body structures (such as cardiovascular, digestive, nervous, integumentary, genitourinary systems, and structures related to movement) and values, beliefs, and spirituality.

- Habits, routines, roles, rituals, and behavior patterns.

- Physical and social environments; cultural, personal, temporal and virtual contexts; and activity demands that affect performance.

- Performance skills, including motor and praxis, sensory-perceptual, emotional regulation, cognitive, communication and social skills.
- 2. Methods or approaches selected to direct the process of interventions, including:
 - Establishment of a skill or ability that has not yet developed or remediation or restoration of a skill or ability that is impaired or is in decline.
 - Compensation, modification, or adaptation of activity or environment to enhance performance or to prevent injuries, disorders, or other conditions.
 - Retention and enhancement of skills or abilities without which performance in everyday life activities would decline.
 - Promotion of health and wellness, including the use of self-management strategies, to enable or enhance performance in everyday life activities.
 - Prevention of barriers to performance and participation, including injury and disability prevention.
- 3. Interventions and procedures to promote or enhance safety and performance in activities of daily living (ADL), instrumental activities of daily living (IADL), rest and sleep, education, work, play, leisure, and social participation, including:
 - Therapeutic use of occupations, exercises, and activities.
 - Training in self-care, self-management, health management and maintenance, home management, community/work reintegration, and school activities and work performance.
 - Development, remediation, or compensation of neuromusculoskeletal, sensory-perceptual, visual, mental, and cognitive functions, pain tolerance and management, and behavioral skills.
 - Therapeutic use of self, including one's personality, insights, perceptions, and judgments, as part of the therapeutic process.
 - Education and training of individuals, including family members, caregivers, groups, populations, and others.
 - Care coordination, case management, and transition services.
 - Consultative services to groups, programs, organizations, or communities.
 - Modification of environments (home, work, school, or community) and adaptation of processes, including the application of ergonomic principles.
 - Assessment, design, fabrication, application, fitting, and training in seating and positioning, assistive technology, adaptive devices, and orthotic devices, and training in the use of prosthetic devices.
 - Assessment, recommendation, and training in techniques to enhance functional mobility, including management of wheelchairs and other mobility devices.
 - Low vision rehabilitation.
 - Driver rehabilitation and community mobility.
 - Management of feeding, eating, and swallowing to enable eating and feeding performance.
 - Application of physical agent modalities and use of a range of specific therapeutic procedures (such as wound care management, interventions to enhance sensory-perceptual and cognitive processing, and manual therapy) to enhance performance skills.
 - Facilitating the occupational performance of groups, populations, or organizations through the modification of environments and the adaptation of processes.

"Occupational therapy screening" means a brief process which is directed by an occupational therapist in order for the occupational therapist to render a decision as to whether the individual warrants further, in-depth evaluation and which includes:

1. Assessment of the medical and social history of an individual;
2. Observations related by that individual's caregivers; or
3. Observations or nonstandardized tests, or both, administered to an individual by the occupational therapist or an occupational therapy assistant under the direction of the occupational therapist.

Nothing in this definition shall be construed to prohibit licensed occupational therapists and occupational therapy assistants who work in preschools or school settings from providing short-term

interventions to children prior to an evaluation, not to exceed 16 sessions per concern per school year, in accordance with state and federal educational policy.

"On site" means:

1. To be continuously on site and present in the department or facility where the assistive personnel are performing services;
2. To be immediately available to assist the person being supervised in the services being performed; and
3. To provide continued direction of appropriate aspects of each treatment session in which a component of treatment is delegated to assistive personnel.

"OT" means occupational therapist.

"OTA" means occupational therapy assistant.

"Reactivate" or *"reactivation"* means the process as outlined in rule 206.18(17A,147,272C) by which an inactive license is restored to active status.

"Reciprocal license" means the issuance of an Iowa license to practice occupational therapy to an applicant who is currently licensed in another state which has a mutual agreement with the Iowa board of physical and occupational therapy to license persons who have the same or similar qualifications to those required in Iowa.

"Reinstatement" means the process as outlined in 645—11.31(272C) by which a licensee who has had a license suspended or revoked or who has voluntarily surrendered a license may apply to have the license reinstated, with or without conditions. Once the license is reinstated, the licensee may apply for active status.

[ARC 7644B, IAB 3/25/09, effective 4/29/09; ARC 0223C, IAB 7/25/12, effective 8/29/12]

645—206.2(147) Requirements for licensure. The following criteria shall apply to licensure:

206.2(1) The applicant shall complete a board-approved application packet. Application forms may be obtained from the board's Web site (<http://www.idph.state.ia.us/licensure>) or directly from the board office. All applications shall be sent to Board of Physical and Occupational Therapy, Professional Licensure Division, Fifth Floor, Lucas State Office Building, Des Moines, Iowa 50319-0075.

206.2(2) The applicant shall complete the application form according to the instructions contained in the application. If the application is not completed according to the instructions, the application will not be reviewed by the board.

206.2(3) Each application shall be accompanied by the appropriate fees payable by check or money order to the Board of Physical and Occupational Therapy. The fees are nonrefundable.

206.2(4) No application will be considered by the board until official copies of academic transcripts sent directly from the school to the board have been received by the board.

206.2(5) The applicant shall provide a notarized copy of the certificate or diploma indicating the degree awarded to the applicant, if the degree is not indicated on the official transcript.

206.2(6) The licensure examination score shall be sent directly from the examination service to the board to confirm a passing score on the examination.

206.2(7) Licensees who were issued their initial licenses within six months prior to the renewal date shall not be required to renew their licenses until the renewal date two years later.

206.2(8) Incomplete applications that have been on file in the board office for more than two years shall be:

- a. Considered invalid and shall be destroyed; or
- b. Maintained upon written request of the candidate. The candidate is responsible for requesting that the file be maintained.

645—206.3(147) Limited permit to practice pending licensure. A limited permit holder who is applying for licensure in Iowa by taking the licensure examination for the first time and has never been licensed as an occupational therapist or occupational therapy assistant in any state, the District of Columbia, or another country must have completed the educational and experience requirements for licensure as an occupational therapist or occupational therapy assistant. The limited permit holder shall:

1. Make arrangements to take the examination and have the official results of the examination sent directly from the examination service to the board;
2. Apply for licensure on forms provided by the board. The applicant must include on the application form the name of the Iowa-licensed occupational therapist(s) who will provide supervision of the limited permit holder until the limited permit holder is licensed;
3. Practice only under the supervision of an Iowa-licensed OT for a period not to exceed six months from the date the application was received in the board office;
4. Submit to the board the name of the OT providing supervision within seven days after a change in supervision occurs; and
5. If the applicant fails the national examination, the limited permit holder must cease practicing immediately.

645—206.4(147) Applicant occupational therapist and occupational therapy assistant. An applicant who has never been licensed in Iowa, but has taken the licensure examination and held licensure in another state, the District of Columbia, or another country may practice under these rules prior to licensure if the complete application for endorsement and fees are on file at the board office. The occupational therapist applicant and occupational therapy assistant applicant shall:

1. Apply for licensure on forms provided by the board. The applicant must include on the application form the name of the Iowa-licensed OT who will provide supervision of the applicant until the applicant is licensed;
2. Practice only under the supervision of an Iowa-licensed OT for a period not to exceed three months from the date the application was received in the board office;
3. Submit to the board the name of the occupational therapist(s) providing supervision within seven days after a change in supervision occurs; and
4. The applicant shall not practice as an OT applicant or OTA applicant if the applicant has never passed the licensure examination.

645—206.5(147) Practice of occupational therapy limited permit holders and endorsement applicants prior to licensure.

206.5(1) Occupational therapist limited permit holders and endorsement applicants working prior to licensure may:

- a. Evaluate clients, plan treatment programs, and provide periodic reevaluations only under supervision of a licensed OT who shall bear full responsibility for care provided under the OT's supervision; and
- b. Perform the duties of the occupational therapist under the supervision of an Iowa-licensed occupational therapist, except for providing supervision to an occupational therapy assistant.

206.5(2) Occupational therapy assistants, limited permit holders and endorsement applicants working prior to licensure shall:

- a. Follow the treatment plan written by the supervising OT outlining the elements that have been delegated; and
- b. Perform occupational therapy procedures delegated by the supervising OT as required in subrule 206.8(4).

645—206.6(147) Examination requirements. The following criteria shall apply to the written examination(s):

206.6(1) The applicant for licensure as an occupational therapist shall have received a passing score on the licensure examination for occupational therapists. It is the responsibility of the applicant to make arrangements to take the examination and have the official results submitted directly from the examination service to the board of physical and occupational therapy.

206.6(2) The applicant for licensure as an occupational therapy assistant shall have received a passing score on the licensure examination for occupational therapy assistants. It is the responsibility

of the applicant to make arrangements to take the examination and have the official results submitted directly from the examination service to the board of physical and occupational therapy.

645—206.7(147) Educational qualifications.

206.7(1) The applicant must present proof of meeting the following requirements for licensure as an occupational therapist or occupational therapy assistant:

a. Occupational therapist. The applicant for licensure as an occupational therapist shall have completed the requirements for a degree in occupational therapy in an occupational therapy program accredited by the Accreditation Council for Occupational Therapy Education of the American Occupational Therapy Association. The transcript shall show completion of a supervised fieldwork experience.

b. Occupational therapy assistant. The applicant for licensure as an occupational therapy assistant shall be a graduate of an educational program approved by the Accreditation Council for Occupational Therapy Education of the American Occupational Therapy Association. The transcript shall show completion of a supervised fieldwork experience.

206.7(2) Foreign-trained occupational therapists and occupational therapy assistants. To become eligible to take the licensure examination, internationally educated occupational therapists must meet NBCOT eligibility requirements and undergo prescreening based on the status of their occupational therapy educational programs.

645—206.8(148B) Supervision requirements.

206.8(1) Care rendered by unlicensed assistive personnel shall not be documented or charged as occupational therapy unless direct on-site supervision is provided by an OT or in-sight supervision is provided by an OTA.

206.8(2) Occupational therapist supervisor responsibilities. The supervisor shall:

a. Provide supervision to a licensed OTA, OT limited permit holder and OTA limited permit holder.

b. Provide on-site supervision or supervision by telecommunication as long as the occupational therapy services are rendered in accordance with the provisions of subrule 206.8(5).

c. Assume responsibility for all delegated tasks and shall not delegate a service which exceeds the expertise of the OTA or OTA limited permit holder.

d. Provide evaluation and development of a treatment plan for use by the OTA.

e. Ensure that the OTA, OT limited permit holder and OTA limited permit holder under the OT's supervision have current licenses to practice.

f. Ensure that the signature of an OTA on an occupational therapy treatment record indicates that the occupational therapy services were provided in accordance with the rules and regulations for practicing as an OTA.

206.8(3) The following are functions that only an occupational therapist may provide and that shall not be delegated to an OTA:

a. Interpretation of referrals;

b. Initial occupational therapy evaluation and reevaluations;

c. Identification, determination or modification of patient problems, goals, and care plans;

d. Final discharge evaluation and establishment of the discharge plan;

e. Assurance of the qualifications of all assistive personnel to perform assigned tasks through written documentation of their education or training that is maintained and available at all times;

f. Delegation of and instruction in the services to be rendered by the OTA including, but not limited to, specific tasks or procedures, precautions, special problems, and contraindicated procedures; and

g. Timely review of documentation, reexamination of the patient and revision of the plan when indicated.

206.8(4) Supervision of unlicensed assistive personnel. OTs are responsible for patient care provided by unlicensed assistive personnel under the OT's supervision. Unlicensed assistive personnel shall not provide independent patient care unless each of the following standards is satisfied:

- a. The supervising OT shall physically participate in the patient's treatment or evaluation, or both, each treatment day;
- b. The unlicensed assistive personnel shall provide independent patient care only while under the on-site supervision of the supervising OT;
- c. Documentation made in occupational therapy records by unlicensed assistive personnel shall be cosigned by the supervising OT; and
- d. The supervising OT shall provide periodic reevaluation of the performance of unlicensed assistive personnel in relation to the patient.

206.8(5) The OT must participate in treatment including direct face-to-face patient contact every twelfth visit or 60 calendar days, whichever comes first, for all patients regardless of setting and must document each visit.

206.8(6) Occupational therapy assistant responsibilities.

a. The occupational therapy assistant:

- (1) Shall provide only those services for which the OTA has the necessary skills and shall consult the supervising occupational therapist if the procedures are believed not to be in the best interest of the patient;
- (2) Shall gather data relating to the patient's disability during screening, but shall not interpret the patient information as it pertains to the plan of care;
- (3) Shall communicate any change, or lack of change, which occurs in the patient's condition and which may need the assessment of the OT;
- (4) Shall provide occupational therapy services only under the supervision of the occupational therapist;
- (5) Shall provide treatment only after evaluation and development of a treatment plan by the occupational therapist;
- (6) Shall refer inquiries that require interpretation of patient information to the occupational therapist;
- (7) Shall have on-site or immediate telecommunicative supervision as long as the occupational therapy services are rendered in accordance with the provisions of subrule 206.8(5);
- (8) May receive supervision from any number of occupational therapists;
- (9) Shall maintain documentation of supervision on a daily basis that shall be available for review upon request of the board.

b. The signature of an OTA on the occupational therapy treatment record indicates that occupational therapy services were provided in accordance with the rules and regulations for practicing as an OTA.

206.8(7) Unlicensed assistive personnel. Unlicensed assistive personnel may assist an OTA in providing patient care in the absence of an OT only if the OTA maintains in-sight supervision of the unlicensed assistive personnel and the OTA is primarily and significantly involved in that patient's care.

206.8(8) The occupational therapy limited permit holder may evaluate clients, plan treatment programs, and provide periodic reevaluations under supervision of a licensed occupational therapist who shall bear full responsibility for care provided under the occupational therapist's supervision.

[ARC 0223C, IAB 7/25/12, effective 8/29/12]

645—206.9(147) Licensure by endorsement. An applicant who has been a licensed occupational therapist or occupational therapy assistant under the laws of another jurisdiction shall file an application for licensure by endorsement with the board office. The board may receive by endorsement any applicant from the District of Columbia, another state, territory, province or foreign country who:

1. Submits to the board a completed application;
2. Pays the licensure fee;

3. Shows evidence of licensure requirements in the jurisdiction in which the applicant has been licensed that are similar to those required in Iowa;
4. Submits official results from the appropriate professional examination sent directly from the examination service to the board;
5. Provides official copies of the academic transcripts sent directly from the school to the board;
6. Provides verification of license(s) from every jurisdiction in which the applicant has been licensed, sent directly from the jurisdiction(s) to the board office. Web-based verification may be substituted for verification direct from the jurisdiction's board office if it provides:
 - Licensee's name;
 - Date of initial licensure;
 - Current licensure status; and
 - Any disciplinary action taken against the license; and
7. Shows evidence of one of the following:
 - Completion of 30 hours for an occupational therapist and 15 hours for an occupational therapy assistant of board-approved continuing education during the immediately preceding two-year period;
 - The practice of occupational therapy for a minimum of 2,080 hours during the immediately preceding two-year period as a licensed occupational therapist or occupational therapy assistant;
 - Serving as a full-time equivalent faculty member teaching occupational therapy in an accredited school of occupational therapy for at least one of the immediately preceding two years; or
 - Successfully passing the examination within a period of one year from the date of examination to the time application is completed for licensure.

Individuals who were issued their licenses by endorsement within six months of the license renewal date will not be required to renew their licenses until the next renewal two years later.
[ARC 0223C, IAB 7/25/12, effective 8/29/12]

645—206.10(147) License renewal.

206.10(1) The biennial license renewal period for a license to practice as an occupational therapist or occupational therapy assistant shall begin on the sixteenth day of the birth month and end on the fifteenth day of the birth month two years later. The licensee is responsible for renewing the license prior to its expiration. Failure of the licensee to receive notice from the board does not relieve the licensee of the responsibility for renewing the license.

206.10(2) An individual who was issued a license within six months of the license renewal date will not be required to renew the license until the subsequent renewal two years later.

206.10(3) A licensee seeking renewal shall:

a. Meet the continuing education requirements of rule 645—207.2(272C) and the mandatory reporting requirements of subrule 206.12(4). A licensee whose license was reactivated during the current renewal compliance period may use continuing education earned during the compliance period for the first renewal following reactivation; and

b. Submit the completed renewal application and renewal fee before the license expiration date.

206.10(4) Mandatory reporter training requirements.

a. A licensee who in the scope of professional practice regularly examines, attends, counsels or treats children in Iowa shall indicate on the renewal application completion of two hours of training in child abuse identification and reporting in the previous five years or condition(s) for waiver of this requirement as identified in paragraph "e."

b. A licensee who in the scope of professional practice regularly examines, attends, counsels or treats adults in Iowa shall indicate on the renewal application completion of two hours of training in dependent adult abuse identification and reporting in the previous five years or condition(s) for waiver of this requirement as identified in paragraph "e."

c. A licensee who in the scope of professional practice regularly examines, attends, counsels or treats both adults and children in Iowa shall indicate on the renewal application completion of training in abuse identification and reporting for dependent adults and children in the previous five years or condition(s) for waiver of this requirement as identified in paragraph "e."

Training may be completed through separate courses as identified in paragraphs "a" and "b" or in one combined two-hour course that includes curricula for identifying and reporting child abuse and dependent adult abuse. The course shall be a curriculum approved by the Iowa department of public health abuse education review panel.

d. The licensee shall maintain written documentation for five years after mandatory training as identified in paragraphs "a" to "c," including program date(s), content, duration, and proof of participation.

e. The requirement for mandatory training for identifying and reporting child and dependent adult abuse shall be suspended if the board determines that suspension is in the public interest or that a person at the time of license renewal:

(1) Is engaged in active duty in the military service of this state or the United States.

(2) Holds a current waiver by the board based on evidence of significant hardship in complying with training requirements, including an exemption of continuing education requirements or extension of time in which to fulfill requirements due to a physical or mental disability or illness as identified in 645—Chapter 4.

f. The board may select licensees for audit of compliance with the requirements in paragraphs "a" to "e."

206.10(5) Upon receiving the information required by this rule and the required fee, board staff shall administratively issue a two-year license and shall send the licensee a wallet card by regular mail. In the event the board receives adverse information on the renewal application, the board shall issue the renewal license but may refer the adverse information for further consideration or disciplinary investigation.

206.10(6) Persons licensed to practice as occupational therapists or occupational therapy assistants shall keep their renewal licenses displayed in a conspicuous public place at the primary site of practice.

206.10(7) Late renewal. The license shall become a late license when the license has not been renewed by the expiration date on the wallet card. The licensee shall be assessed a late fee as specified in 645—subrule 5.11(4). To renew a late license, the licensee shall complete the renewal requirements and submit the late fee within the grace period.

206.10(8) Inactive license. A licensee who fails to renew the license by the end of the grace period has an inactive license. A licensee whose license is inactive continues to hold the privilege of licensure in Iowa, but may not practice as an occupational therapist or occupational therapy assistant in Iowa until the license is reactivated. A licensee who practices as an occupational therapist or occupational therapy assistant in the state of Iowa with an inactive license may be subject to disciplinary action by the board, injunctive action pursuant to Iowa Code section 147.83, criminal sanctions pursuant to Iowa Code section 147.86, and other available legal remedies.

[ARC 0223C, IAB 7/25/12, effective 8/29/12]

645—206.11(17A,147,272C) License reactivation. To apply for reactivation of an inactive license, a licensee shall:

206.11(1) Submit a reactivation application on a form provided by the board.

206.11(2) Pay the reactivation fee that is due as specified in 645—subrule 5.11(5).

206.11(3) Provide verification of current competence to practice occupational therapy by satisfying one of the following criteria:

a. If the license has been on inactive status for five years or less, an applicant must provide the following:

(1) Verification of the license(s) from every jurisdiction in which the applicant is or has been licensed and is or has been practicing during the time period the Iowa license was inactive, sent directly from the jurisdiction(s) to the board office. Web-based verification may be substituted for verification from a jurisdiction's board office if the verification includes:

1. Licensee's name;
2. Date of initial licensure;
3. Current licensure status; and
4. Any disciplinary action taken against the license; and

(2) Verification of completion of 15 hours of continuing education for an occupational therapy assistant and 30 hours of continuing education for an occupational therapist within two years of application for reactivation.

b. If the license has been on inactive status for more than five years, an applicant must provide the following:

(1) Verification of the license(s) from every jurisdiction in which the applicant is or has been licensed and is or has been practicing during the time period the Iowa license was inactive, sent directly from the jurisdiction(s) to the board office. Web-based verification may be substituted for verification from a jurisdiction's board office if the verification includes:

1. Licensee's name;
2. Date of initial licensure;
3. Current licensure status; and
4. Any disciplinary action taken against the license; and

(2) Verification of completion of 30 hours of continuing education for an occupational therapy assistant and 60 hours of continuing education for an occupational therapist within two years of application for reactivation; or evidence of successful completion of the professional examination required for initial licensure completed within one year prior to the submission of an application for reactivation.

[ARC 0223C, IAB 7/25/12, effective 8/29/12]

645—206.12(17A,147,272C) License reinstatement. A licensee whose license has been revoked, suspended, or voluntarily surrendered must apply for and receive reinstatement of the license in accordance with 645—11.31(272C) and must apply for and be granted reactivation of the license in accordance with 206.18(17A,147,272C) prior to practicing occupational therapy in this state.
[ARC 0223C, IAB 7/25/12, effective 8/29/12]

645—206.13(272C) Exemptions for inactive practitioners. Rescinded IAB 9/14/05, effective 10/19/05.

645—206.14(272C) Lapsed licenses. Rescinded IAB 9/14/05, effective 10/19/05.

645—206.15(147) Duplicate certificate or wallet card. Rescinded IAB 12/17/08, effective 1/21/09.

645—206.16(147) Reissued certificate or wallet card. Rescinded IAB 12/17/08, effective 1/21/09.

645—206.17(17A,147,272C) License denial. Rescinded IAB 12/17/08, effective 1/21/09.

These rules are intended to implement Iowa Code chapters 17A, 147, 148B and 272C.

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^o Two or more ARCs

CHAPTER 148A

PHYSICAL THERAPY

Referred to in §135.24, 135.61, 147.74, 147.76, 714H.4

[P]
 Enforcement, §147.87, 147.92
 Penalty, §147.86

148A.1	Definitions — referral — authorization.	148A.4	Requirements to practice.
148A.2	Who engaged in practice.	148A.5	Limitations.
148A.3	Persons not included.	148A.6	Physical therapist assistant.
		148A.7	False use of titles prohibited.

148A.1 Definitions — referral — authorization.

1. a. As used in this chapter, “board” means the board of physical and occupational therapy created under chapter 147.

b. As used in this chapter, “physical therapy” is that branch of science that deals with the evaluation and treatment of human capabilities and impairments. Physical therapy uses the effective properties of physical agents including, but not limited to, mechanical devices, heat, cold, air, light, water, electricity, and sound, and therapeutic exercises, and rehabilitative procedures to prevent, correct, minimize, or alleviate a physical impairment. Physical therapy includes the interpretation of performances, tests, and measurements, the establishment and modification of physical therapy programs, treatment planning, consultative services, instructions to the patients, and the administration and supervision attendant to physical therapy facilities.

2. Physical therapy evaluation and treatment may be rendered by a physical therapist with or without a referral from a physician, podiatric physician, dentist, or chiropractor, except that a hospital may require that physical therapy evaluation and treatment provided in the hospital shall be done only upon prior review by and authorization of a member of the hospital’s medical staff.

[C66, 71, 73, 75, 77, 79, 81, §148A.1]

84 Acts, ch 1268, §1; 86 Acts, ch 1238, §7; 87 Acts, ch 65, §3; 88 Acts, ch 1002, §1; 95 Acts, ch 108, §8; 2007 Acts, ch 10, §99

Referred to in §148A.3

148A.2 Who engaged in practice.

For the purpose of this chapter the following classes of persons shall be deemed to be engaged in the practice of physical therapy:

1. Persons who treat human ailments by physical therapy as defined in this chapter.
2. Persons who publicly profess to be physical therapists or who publicly profess to perform the functions incident to the practice of physical therapy.

[C66, 71, 73, 75, 77, 79, 81, §148A.2]

148A.3 Persons not included.

Section 148A.1 shall not be construed to include the following classes of persons:

1. Licensed physicians and surgeons, osteopathic physicians and surgeons, podiatric physicians, chiropractors, nurses, dentists, cosmetologists, and barbers, who are engaged in the practice of their respective professions.
2. Students of physical therapy who practice physical therapy under the supervision of a licensed physical therapist in connection with the regular course of instruction at a school of physical therapy.
3. Physical therapists of the United States army, navy, or public health service, or physical therapists licensed in another state, when incidentally called into this state in consultation with a physician and surgeon or physical therapists licensed in this state.
4. Nonprofessional workers not held out as physical therapists who are employed in hospitals, clinics, offices or health care facilities as defined in section 135C.1 working under

the supervision and direction of a physical therapist or physician licensed pursuant to chapter 148.

5. Massage therapists, massage technicians, masseurs and masseuses who administer body massage by Swedish or other massage technique, including modalities, in a massage establishment, health club, athletic club or school athletic department, but in no instance shall they designate themselves as physical therapists.

[C66, 71, 73, 75, 77, 79, 81, §148A.3]

84 Acts, ch 1268, §2; 96 Acts, ch 1034, §68; 2008 Acts, ch 1088, §100

148A.4 Requirements to practice.

Each applicant for a license to practice physical therapy shall:

1. Complete a course of study in, and hold a diploma or certificate issued by, a school of physical therapy accredited by the American physical therapy association or another appropriate accrediting body, and meet requirements as established by rules of the board.

2. Have passed an examination administered by the board.

[C66, 71, 73, 75, 77, 79, 81, §148A.4]

83 Acts, ch 101, §27; 84 Acts, ch 1268, §3; 2007 Acts, ch 10, §100

148A.5 Limitations.

A license to practice physical therapy does not authorize the licensee to practice operative surgery or osteopathic or chiropractic manipulation, or to administer or prescribe any drug or medicine included in materia medica.

88 Acts, ch 1002, §2

148A.6 Physical therapist assistant.

1. A licensed physical therapist assistant is required to function under the direction and supervision of a licensed physical therapist to perform physical therapy procedures delegated and supervised by the licensed physical therapist in a manner consistent with the rules adopted by the board. Selected and delegated tasks of physical therapist assistants may include but are not limited to therapeutic procedures and related tasks, routine operational functions, documentation of treatment progress, and the use of selected physical agents. The ability of the licensed physical therapist assistant to perform the selected and delegated tasks shall be assessed on an ongoing basis by the supervising physical therapist. The licensed physical therapist assistant shall not interpret referrals, perform initial evaluation or reevaluations, initiate physical therapy treatment programs, change specified treatment programs, or discharge a patient from physical therapy services.

2. Each applicant for a license to practice as a physical therapist assistant shall:

a. Successfully complete a course of study for the physical therapist assistant accredited by the commission on accreditation in education of the American physical therapy association, or another appropriate accrediting body, and meet other requirements established by the rules of the board.

b. Have passed an examination administered by the board.

3. This section does not prevent a person not licensed as a physical therapist assistant from performing services ordinarily performed by a physical therapy aide, assistant, or technician, provided that the person does not represent to the public that the person is a licensed physical therapist assistant, or use the title "physical therapist assistant" or the letters "P.T.A.", and provided that the person performs services consistent with the supervision requirements of the board for persons not licensed as physical therapist assistants.

91 Acts, ch 228, §3; 2000 Acts, ch 1140, §33; 2004 Acts, ch 1068, §2; 2007 Acts, ch 10, §101

148A.7 False use of titles prohibited.

1. A person or business entity, including the employees, agents, or representatives of the business entity, shall not use in connection with that person's or business entity's business activity the words "physical therapy", "physical therapist", "licensed physical therapist", "registered physical therapist", "doctor of physical therapy", "physical therapist assistant",

"licensed physical therapist assistant", "registered physical therapist assistant", or the letters "P.T.", "L.P.T.", "R.P.T.", "D.P.T.", "P.T.A.", "L.P.T.A.", "R.P.T.A.", or any other words, abbreviations, or insignia indicating or implying that physical therapy is provided or supplied, unless such services are provided by or under the direction and supervision of a physical therapist licensed pursuant to this chapter.

2. Notwithstanding section 147.74, a person or the owner, officer, or agent of an entity that violates this section is guilty of a serious misdemeanor, and a license to practice shall be revoked or suspended pursuant to section 147.55.

3. This section shall not apply to the use of the term "physiotherapy" by a provider licensed under this chapter, chapter 151, or by an individual under the direction and supervision of a provider licensed under this chapter or chapter 151.

2004 Acts, ch 1068, §1; 2009 Acts, ch 133, §56

CHAPTER 201
PRACTICE OF PHYSICAL THERAPISTS
AND PHYSICAL THERAPIST ASSISTANTS

645—201.1(148A,272C) Code of ethics for physical therapists and physical therapist assistants.

201.1(1) Physical therapy. The practice of physical therapy shall minimally consist of:

- a. Interpreting all referrals;
- b. Evaluating each patient;
- c. Identifying and documenting individual patient's problems and goals;
- d. Establishing and documenting a plan of care;
- e. Providing appropriate treatment;
- f. Determining the appropriate portions of the treatment program to be delegated to assistive personnel;
- g. Appropriately supervising individuals as described in rule 645—200.6(272C);
- h. Providing timely patient reevaluation;
- i. Maintaining timely and adequate patient records of all physical therapy activity and patient responses consistent with the standards found in rule 645—201.2(147).

201.1(2) A physical therapist shall:

- a. Not practice outside the scope of the license;
- b. Inform a referring practitioner when any requested treatment procedure is inadvisable or contraindicated and shall refuse to carry out such orders;
- c. Not continue treatment beyond the point of possible benefit to the patient or treat a patient more frequently than necessary to obtain maximum therapeutic effect;
- d. Not directly or indirectly request, receive, or participate in the dividing, transferring, assigning, rebating, or refunding of an unearned fee;
- e. Not profit by means of credit or other valuable consideration as an unearned commission, discount, or gratuity in connection with the furnishing of physical therapy services;
- f. Not obtain third-party payment through fraudulent means. Third-party payers include, but are not limited to, insurance companies and government reimbursement programs. Obtaining payment through fraudulent means includes, but is not limited to:
 - (1) Reporting incorrect treatment dates for the purpose of obtaining payment;
 - (2) Reporting charges for services not rendered;
 - (3) Incorrectly reporting services rendered for the purpose of obtaining payment which is greater than that to which the licensee is entitled; or
 - (4) Aiding a patient in fraudulently obtaining payment from a third-party payer;
- g. Not exercise undue influence on patients to purchase equipment, products, or supplies from a company in which the physical therapist owns stock or has any other direct or indirect financial interest;
- h. Not permit another person to use the therapist's license for any purpose;
- i. Not verbally or physically abuse a patient or client;
- j. Not engage in sexual misconduct. Sexual misconduct includes the following:
 - (1) Engaging in or soliciting a sexual relationship, whether consensual or nonconsensual, with a patient or client;
 - (2) Making sexual advances, requesting sexual favors, or engaging in other verbal conduct or physical contact of a sexual nature with a patient or client;
- k. Adequately supervise personnel in accordance with the standards for supervision found in rule 645—200.6(272C);
- l. Assist in identifying a professionally qualified licensed practitioner to perform the service, in the event that the physical therapist does not possess the skill to evaluate a patient, plan the treatment program, or carry out the treatment.

201.1(3) Physical therapist assistants. A physical therapist assistant shall:

- a. Not practice outside the scope of the license;

b. Not obtain third-party payment through fraudulent means. Third-party payers include, but are not limited to, insurance companies and government reimbursement programs. Obtaining payment through fraudulent means includes, but is not limited to:

- (1) Reporting incorrect treatment dates for the purpose of obtaining payment;
- (2) Reporting charges for services not rendered;
- (3) Incorrectly reporting services rendered for the purpose of obtaining payment which is greater than that to which the licensee is entitled; or

- (4) Aiding a patient in fraudulently obtaining payment from a third-party payer;

c. Not exercise undue influence on patients to purchase equipment, products, or supplies from a company in which the physical therapist assistant owns stock or has any other direct or indirect financial interest;

d. Not permit another person to use the physical therapist's or physical therapist assistant's license for any purpose;

e. Not verbally or physically abuse a patient or client;

f. Not engage in sexual misconduct. Sexual misconduct includes the following:

(1) Engaging in or soliciting a sexual relationship, whether consensual or nonconsensual, with a patient or client; and

(2) Making sexual advances, requesting sexual favors, or engaging in other verbal conduct or physical contact of a sexual nature with a patient or client;

g. Work only when supervised by a physical therapist and in accordance with rule 645—200.6(272C). If the available supervision does not meet the standards in rule 645—200.6(272C), the physical therapist assistant shall refuse to administer treatment;

h. Inform the delegating physical therapist when the physical therapist assistant does not possess the skills or knowledge to perform the delegated tasks, and refuse to perform the delegated tasks;

i. Sign the physical therapy treatment record to indicate that the physical therapy services were provided in accordance with the rules and regulations for practicing as a physical therapist or physical therapist assistant.

645—201.2(147) Record keeping.

201.2(1) A licensee shall maintain sufficient, timely, and accurate documentation in patient records. A licensee's records shall reflect the services provided, facilitate the delivery of services, and ensure continuity of services in the future.

201.2(2) A licensee who provides clinical services shall store records in accordance with state and federal statutes and regulations governing record retention and with the guidelines of the licensee's employer or agency, if applicable. If no other legal provisions govern record retention, a licensee shall store all patient records for a minimum of five years after the date of the patient's discharge, or, in the case of a minor, three years after the patient reaches the age of majority under state law or five years after the date of discharge, whichever is longer.

201.2(3) Electronic record keeping. The requirements of this rule apply to electronic records as well as to records kept by any other means. When electronic records are kept, the licensee shall ensure that a duplicate hard-copy record or a backup, unalterable electronic record is maintained.

201.2(4) Correction of records.

a. *Hard-copy records.* Notations shall be legible, written in ink, and contain no erasures or whiteouts. If incorrect information is placed in the record, it must be crossed out with a single nondeleting line and be initialed by the licensee.

b. *Electronic records.* If a record is stored in an electronic format, the record may be amended with a signed addendum attached to the record.

201.2(5) Confidentiality and transfer of records. Physical therapists and physical therapist assistants shall preserve the confidentiality of patient records. Upon receipt of a written release or authorization signed by the patient, the licensee shall furnish such physical therapy records, or copies of the records, as will be beneficial for the future treatment of that patient. A fee may be charged for duplication of

records, but a licensee may not refuse to transfer records for nonpayment of any fees. A written request may be required before transferring the record(s).

201.2(6) Retirement or discontinuance of practice. If a licensee is the owner of a practice, the licensee shall notify in writing all active patients and shall make reasonable arrangements with those patients to transfer patient records, or copies of those records, to the succeeding licensee upon knowledge and agreement of the patient.

201.2(7) Nothing stated in these rules shall prohibit a licensee from conveying or transferring the licensee's patient records to another licensed individual who is assuming a practice, provided that written notice is furnished to all patients.

These rules are intended to implement Iowa Code chapters 147, 148A and 272C.

[Filed 11/26/03, Notice 9/17/03—published 12/24/03, effective 1/28/04]

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TITLE 21--FOOD AND DRUGS
CHAPTER I--FOOD AND DRUG ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES
SUBCHAPTER H--MEDICAL DEVICES
PART 801 -- LABELING

Subpart D--Exemptions From Adequate Directions for Use

Sec. 801.109 Prescription devices.

A device which, because of any potentiality for harmful effect, or the method of its use, or the collateral measures necessary to its use is not safe except under the supervision of a practitioner licensed by law to direct the use of such device, and hence for which "adequate directions for use" cannot be prepared, shall be exempt from section 502(f)(1) of the act if all the following conditions are met:

(a) The device is:

- (1)(i) In the possession of a person, or his agents or employees, regularly and lawfully engaged in the manufacture, transportation, storage, or wholesale or retail distribution of such device; or
- (ii) In the possession of a practitioner, such as physicians, dentists, and veterinarians, licensed by law to use or order the use of such device; and

(2) Is to be sold only to or on the prescription or other order of such practitioner for use in the course of his professional practice.

(b) The label of the device, other than surgical instruments, bears:

- (1) The statement "Caution: Federal law restricts this device to sale by or on the order of a _____", the blank to be filled with the word "physician", "dentist", "veterinarian", or with the descriptive designation of any other practitioner licensed by the law of the State in which he practices to use or order the use of the device; and

(2) The method of its application or use.

(c) Labeling on or within the package from which the device is to be dispensed bears information for use, including indications, effects, routes, methods, and frequency and duration of administration, and any relevant hazards, contraindications, side effects, and precautions under which practitioners licensed by law to administer

the device can use the device safely and for the purpose for which it is intended, including all purposes for which it is advertised or represented: *Provided, however, That such information may be omitted from the dispensing package if, but only if, the article is a device for which directions, hazards, warnings, and other information are commonly known to practitioners licensed by law to use the device.* Upon written request, stating reasonable grounds therefor, the Commissioner will offer an opinion on a proposal to omit such information from the dispensing package under this proviso.

(d) Any labeling, as defined in section 201(m) of the act, whether or not it is on or within a package from which the device is to be dispensed, distributed by or on behalf of the manufacturer, packer, or distributor of the device, that furnishes or purports to furnish information for use of the device contains adequate information for such use, including indications, effects, routes, methods, and frequency and duration of administration and any relevant hazards, contraindications, side effects, and precautions, under which practitioners licensed by law to employ the device can use the device safely and for the purposes for which it is intended, including all purposes for which it is advertised or represented. This information will not be required on so-called reminder--piece labeling which calls attention to the name of the device but does not include indications or other use information.

(e) All labeling, except labels and cartons, bearing information for use of the device also bears the date of the issuance or the date of the latest revision of such labeling.

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5. <http://www.fda.gov/MedicalDevices/DeviceRegulationandGuidance/Databases/default.htm>
6. </scripts/cdrh/cfdocs/search/default.cfm?FAQ=true>
7. <http://www.fda.gov/MedicalDevices/DeviceRegulationandGuidance/Databases/ucm135680.htm>
8. /scripts/cdrh/devicesatfda/index.cfm?Search_Term=Prescription%20devices%2E

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U.S. Food and Drug Administration
10903 New Hampshire Avenue
Silver Spring, MD 20993

Positions on Dry Needling Debate by State

State	Allowed	Not Allowed	Board Ruling	Legislative Ruling	Explanation	Sources
Alabama	X		Unofficial		The Alabama Board had an informal discussion in which they discussed in October 2007 that "Acupuncture and Dry Needling does fall within the scope of practice for physical therapy." There is no further mention of dry needling, invasive therapies or mechanical devices on the Alabama PT Board website.	Kinetacore
Alaska	X		Unofficial		Letter dated April 24 2012. The Board will not address specific treatment approaches by licensure. Individuals PTs will be held accountable for demonstrating competence if there is ever a complaint.	Kinetacore
Arizona	X			X	2014. Law passed adding dry needling to licensure scope.	
Arkansas	X		Unofficial		2009 Discussion. Dry Needling is within the scope of a PT.	
California		X			Couldn't find any online documentation.	
Colorado	X*		X		Section 211. Requirements for PTs to Perform DN D. To be deemed competent to perform dry needling, a PT must: 1. Have practiced for at least 2 yrs as a licensed PT 2. Have successfully completed a dry needling course of study that consists of a min. of 46 hrs of in-person (i.e. not online) DN training.	

Positions on Dry Needling Debate by State

State	Allowed	Not Allowed	Board Ruling	Legislative Ruling	Explanation	Sources
Connecticut		X	X		“Modulation and restoration of normal function in and between the body’s energetic and organ systems and biochemical, metabolic and circulation functions using stimulation of selected points by inserting needles, including, trigger point, subcutaneous and dry needling, and other methods consistent with accepted standards within the acupuncture and Oriental medicine profession....”	
Delaware		X	Unofficial		No formal ruling. Discussion by PT board and Attorney General of State —DN is not part of the PT license definition and the definition is not, or cannot, be expanded. Expansion must be done legislatively.	
District of Columbia	X*		Unofficial		The Board allows PTs to perform DN and “strongly recommends completion of a board-approved or Commission on Accreditation in Physical Therapy Education (CAPTE) approved professional training program.”	CAPTE
Florida		X	Unofficial		No formal ruling. The PT Board does not have the power to make a rule of scope of practice necessary to grant them the ability to allow DN in their scope.	

Positions on Dry Needling Debate by State

State	Allowed	Not Allowed	Board Ruling	Legislative Ruling	Explanation	Sources
Georgia	X			X	PT's changed definition under the Georgia Physical Therapy Act states the term "physical therapy" includes "examining, evaluating and testing patients; alleviating impairments; reducing the risk of injury, impairment, activity limitations; dry needling for preventative and therapeutic purposes; instructive, consultative, educational, and other advisory services."	
Hawaii		X	X		DN is not in the scope of practice for PTs in Hawaii.	
Idaho					No official position.	
Illinois		X		X	April 26 2014 The Illinois Dept of Professional Regulation ruled that DN is not within the scope of practice for PTs	
Indiana	X		Unofficial		No official position. INAPTA refers to the National Association's "White Paper" from January 2012 as their reasoning.	
Iowa	X		Unofficial		Currently, the PT Board states DN is within their scope of practice.	
Kansas		X		X	"Dry Needling" is merely another name for acupuncture, and may only be performed by L.Ac.	
Kentucky	X			Unofficial.	The Attorney General holds the opinion that DN is within the scope of practice for PT's, but no official stance has been declared.	

Positions on Dry Needling Debate by State

State	Allowed	Not Allowed	Board Ruling	Legislative Ruling	Explanation	Sources
Louisiana	X		X		Conflicting accounts. Rule 123 states that DN is within the scope of practice for PTs, but the Louisiana State Board of Medical Examiners holds that DN is acupuncture. Chiropractors are allowed to perform DN with 50 hours of face-to-face instruction; standards for PTs are unknown.	
Maine					No known stance.	
Maryland	X*			X	Dept. of Health and Mental Hygiene put forth a new proposal where PTs who want to perform DN need to have 230 hours of training that includes: 100 hrs for anatomy and infection control, 80 hrs of DN techniques, and 50 hrs of hands-on practice.	
Massachusetts					Unknown	
Michigan		X	Unofficial		April 16 2013 PT Board re-stated that DN is not with the PT's scope of practice.	
Minnesota			Unofficial		MNPTA: "MNPTA does not have an official stance on the practice of dry needling."	
Mississippi	X*		X		PT Board includes IMT/DN in a PT's scope of practice. The Attorney General of MS supported their right to do so. March 21 2013: The Board ruled that documentation is required for PTs performing DN and that a PT must receive a letter of authorization from the Board prior to commencing the practice of DN for patient care.	

Positions on Dry Needling Debate by State

State	Allowed	Not Allowed	Board Ruling	Legislative Ruling	Explanation	Sources
Missouri	X		Unofficial		No formal decision. February 2014: "Dry needling—consult with board of healing arts—can't do invasive tests but dry needling isn't invasion; it is a continuing education activity to be able to do so using the training to be able to do. We may need to get dry needling defined and/or added to practice act or added on the acupuncture rules as qualified to perform." April 2014: "Does the Board need to take action or continue to monitor? There are 45 schools teaching dry needling in school maybe as a special presentation without competencies assessed. May need to add to our practice act or go to the acupuncturists about adding PT to their practice act to allow doing it in Missouri."	
Montana	X		Unofficial		November 2011 A letter to the PT Board from APTA stated DN is within the PT's scope of practice.	
Nebraska	X*		Unofficial		DN is approved for PTs with training guidelines.	
Nevada	X		X		March 20 2012 PT Board declared DN to be within a PT's scope of practice.	
New Hampshire	X		Unofficial		October 19 2011 PT Board ruled "A PT or PTA can do 'dry needling' if they have been trained to do so." May 15 2013 PT Board ruled "It is not within the scope of practice for a physical therapist assistant to perform dry needling."	

Positions on Dry Needling Debate by State

State	Allowed	Not Allowed	Board Ruling	Legislative Ruling	Explanation	Sources
New Hampshire	X		Unofficial		October 19 2011 PT Board ruled 'A PT or PTA can do 'dry needling' if they have been trained to do so.' May 15 2013 PT Board ruled 'It is not within the scope of practice for a physical therapist assistant to perform dry needling.'	
New Jersey	X		Unofficial		PT's currently claim that DN is within their scope of practice. March 6 2015 Attorney General of NJ "still has yet to issue an opinion on the issue of dry needling by physical therapists as unlicensed acupuncture under New Jersey statutes and regulations."	
New Mexico	X		X		The PT Board determined March 2000 that Section 61-12D-3; par. 1: Number 2. The definition of physical therapy supports this decision.	
New York		X	Unofficial		Early 1990s the NY State Board determined that dry needling was not an entry level skill and therefore could not be practiced by PTs. Re-affirmed in 2007.	

Positions on Dry Needling Debate by State

State	Allowed	Not Allowed	Board Ruling	Legislative Ruling	Explanation	Sources
North Carolina	X*		Unofficial		October 30 2013. PTs can perform Intramuscular Manual Therapy (IMT, aka dry needling) with additional training that demonstrates "knowledge, skill, ability, and competence as follows: Completion of an IMT course of study at a program approved by the Board with a min. of 54 hrs of classroom education, which must also include instruction in the clinical application of IMT."	
North Dakota	X		Unofficial		Board meeting May 13 2013.	
Ohio	X*		Unofficial		January 5 2007 "It is the position of the Physical Therapy Section that nothing in the Ohio Physical Therapy Practice Act prohibits a physical therapist from performing dry needling."	
Oklahoma	X		Unofficial		January 27 2011 The PT Committee of the Board of Medical Licensure and Supervision discussed dry needling. Dry needling is an acupuncture technique and therapy beyond needling of trigger points is the actual practice of acupuncture... The Committee agreed that trigger point dry needling is part of PT practice in many states but anything beyond would be acupuncture.	

Positions on Dry Needling Debate by State

State	Allowed	Not Allowed	Board Ruling	Legislative Ruling	Explanation	Sources
Oregon	X*		Unofficial		February 18 2014 The dry needling of trigger points is likely within the physical therapist scope of practice (excluding PTAs). Further, the Board acknowledges that dry needling of trigger points is an advanced intervention requiring post graduate training and education. In the interest of public safety, until a measure of evidence based training and education can be determined, the Board strongly advises its licensee to not perform dry needling of trigger points.	
Pennsylvania		X	X		“The State Board of PT would like to remind you that ‘Dry Needling’ is not currently within the scope of physical therapist practice within the Commonwealth of Pennsylvania. The Pennsylvania State Board of PT approves many courses that relate to patient care, but are not within the scope of physical therapist practice, such as courses in radiology and surgery, in addition to dry needling. This education is approved in order to ultimately benefit patients. While dry needling is approved in some states/jurisdictions, it is not legal to perform as a physical therapist in the Commonwealth of Pennsylvania.”	

Positions on Dry Needling Debate by State

State	Allowed	Not Allowed	Board Ruling	Legislative Ruling	Explanation	Sources
Rhode Island	X		Unofficial		February 14 2012 “The Board administrator related guidance from attorney Tom Corrigan stating the use of a needle by one profession does not preclude a different profession from having a different use for a needle. Board members comment dry needling is within their scope or practice provided the licensed professional is comfortable trained and has the appropriate background knowledge. For licensed PTs that are not qualified there are educational seminars they may sign up for and gain the required background and training.”	
South Carolina	X		Unofficial		DN is currently within the scope of practice of PTs. However, SCAPTA June 9 2015 stated: “The South Carolina Physical Therapy Association (SCAPTA) has been made aware of a number of complaints that have been filed with the South Carolina Department of Labor, Licensing, and Regulation against PTs related to the performance of dry needling. While dry needling is within the professional and legal scope of physical therapist practice in South Carolina, there is significant concern by SCAPTA about these complaints. Complaints have been filed against both members and non-members across the state.”	

Positions on Dry Needling Debate by State

State	Allowed	Not Allowed	Board Ruling	Legislative Ruling	Explanation	Sources
South Dakota		X	Unofficial		The South Dakota Board of Medical and Osteopathic Examiners consider procedures involving the breaking or altering of human tissue to be the practice of medicine. As such, DN does not fall within the scope of practice for a PT. However, this decision is an advisory opinion rather than an administrative rule or regulation.	
Tennessee		X		Unofficial	The TN Attorney General holds the opinion that DN is not in a PT's scope of practice.	
Texas					No formal stance.	
Utah	X			X	April 1 2015 Utah Governor Gary R Herbert signed into law HB 367 which amends the Utah PT statute to specifically add DN to the physical therapist scope of practice.	
Vermont			Unofficial		The Board cannot specifically address the issue of DN but states "all licensees, no matter what services they provide must practice within their education, training and experience."	
Virginia	X		Unofficial		PT Board voted that DN is within the scope of PT "but should only be practiced under the following conditions: DN is not an entry level skill but an advanced procedure that requires additional training. A PT using dry needling must complete at least 54 hours of post professional training" that proves competency.	

Positions on Dry Needling Debate by State

State	Allowed	Not Allowed	Board Ruling	Legislative Ruling	Explanation	Sources
Washington		X		X	June 2015 King County Superior Court Judge Laura Inveen issued a permanent injunction against PTs finding they lacked the legal authority to practice DN. Under Washington State law, the PT scope of practice does not authorize the insertion of any type of needle.	
West Virginia	X		X		July 18 2012 The West Virginia PT Board ruled that dry needling is within the scope of the practice of physical therapy as defined by West Virginia Code.	
Wisconsin	X		Unofficial		July 2009 The Board considers trigger point dry needling to be within the scope of practice of physical therapy provided licensed physical therapists are properly trained and educated.	
Wyoming	X		Unofficial		August 18 2009 Wyoming Board of PT affirmed that nothing in the current practice Act would preclude PTs from performing dry needling with proper credentials.	

Positions on Dry Needling Debate by State

Final Summary:

Decision	Tally	Which States
Informally or Unofficially Permitted	23	Alabama, Alaska, Arkansas, Colorado, District of Columbia, Indiana, Iowa, Kentucky, Missouri, Montana, Nebraska, New Hampshire, New Jersey, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, Virginia, Wisconsin, Wyoming
Informally or Unofficially Banned	6	Delaware, Florida, Michigan, New York, South Dakota, Tennessee
Legislatively Permitted	4	Arizona, Georgia, Maryland, Utah
Legislatively Banned	2	Illinois, Washington
Board Permitted	5	Louisiana, Mississippi, Nevada, New Mexico, West Virginia
Board Banned	4	Connecticut, Hawaii, Kansas, Pennsylvania
Unknown or No Stance	6	California, Idaho, Maine, Massachusetts, Minnesota, Vermont

State Positions and Sources¹

Alabama:

No Official Stance

Per Alabama PT Board

Currently, the Board's website does not mention DN, invasive therapies, or mechanical devices.

Source: Alabama Code

(4) PHYSICAL THERAPY. The treatment of a human being by the use of exercise, massage, heat, cold, water, radiant energy, electricity or sound for the purpose of correcting or alleviating any physical or mental condition or preventing the development of any physical or mental disability, or the performance of neuromuscular-skeletal tests and measurements to determine the existing and the extent of body malfunction; provided, that physical therapy shall be practiced only upon the referral of a physician licensed to practice medicine or surgery, a dentist licensed to practice dentistry, a licensed chiropractor, a licensed assistant to a physician acting pursuant to a valid supervisory agreement, or a licensed certified registered nurse practitioner in a collaborative agreement with a licensed physician, except as otherwise provided in this chapter. Physical therapy does not include radiology or electrosurgery.

MEDICAL LICENSURE COMMISSION OF ALABAMA RULES & REGULATIONS 545-X-4-.05 Acupuncture Rules and Regulations

- (1) Acupuncture is deemed by the Medical Licensure Commission to be an experimental procedure of which the safety and medical effectiveness has not been established. The Commission therefor determines that while acupuncture practice by licensed physicians should not be absolutely prohibited, some safeguards are necessary to insure that the public is not harmed or victimized by unprofessional practices, such as the unskilled or uninformed application of acupuncture treatment, or unfounded claims of effectiveness.
- (2) The Commission therefore determines that it shall be deemed unprofessional conduct and grounds for action against the license of any physician pursuant to § 34-24-360(a), Ala. Code (1975) for a physician to offer or administer acupuncture treatment except in compliance with the requirements set forth by the Federal Food and Drug Administration in Federal Register Vol. 88, NO. 46, p 6419 (March 9, 1973). In administering this requirement, the Commission establishes the following criteria, which must be adhered to by physicians licensed by the Commission:
 - (a) All acupuncture devices in this State must be labeled properly according to applicable Federal Food and Drug requirements,
 - (b) A physician must secure a patient's informed consent according to the guidelines established at 21 Code of Federal Regulations Section 130/37, and no claims of therapeutic or diagnostic effectiveness may be made by a physician.

¹ Original Copies of All Sources Can Be Requested.

- (3) The Commission hereby announces its intention to require that physicians wishing to investigate and experiment with the use of acupuncture treatment must comply fully with the above state requirements of this Commission and with the requirement of the Federal Food and Drug Administration cited herein.

Alaska:

No Official Stance

April 24, 2012 a letter discussing DN stated that the Board will not address specific treatment approaches by licensure. Individual PTs are held accountable for demonstrating their competence if there is ever a complaint.

Kinetacore:

Currently, Alaska requires 25 hours of continuing education and accepts courses that are approved by the APTA.

Arizona:

Allowed

Per Legislature and Board

2014

PTs wishing to perform DN must now comply with training and education requirements in order to legally practice DN. These requirements include a minimum of 24 contact hours of education, courses in safe needle practices, indications and contraindications, anatomical review, and the course content must be approved by specific organizations as listed below.

Source: April 2 2015 Press Release

BOARD ACTION ON DRY NEEDLING; SB 1154; RULES

Dry Needling Rules

In accordance with legislative directives in SB 1154 passed by the Legislature and signed by the Governor in 2014, the Board of Physical Therapy has drafted rules to set standards of education and training for the intervention "Dry Needling".

The Board reviewed the survey results at the Board's May 19, 2015 Board Meeting. The following rules were adopted May 19, 2015 and are being processed for publication with an effective date of July 1, 2015.

RULES:

A.A.C. R4-24-313: PROFESSIONAL STANDARDS OF CARE AND TRAINING AND EDUCATION QUALIFICATIONS FOR DELIVERY OF DRY NEEDLING SKILLED INTERVENTION

A. EFFECTIVE JULY 1, 2015 AND IN ACCORDANCE WITH A.R.S. §32-2044(25), A PHYSICAL THERAPIST SHALL MEET THE QUALIFICATIONS ESTABLISHED IN PARAGRAPH (C) BEFORE PROVIDING THE SKILLED INTERVENTION "DRY NEEDLING", AS DEFINED IN A.R.S. §32-2001(4).

B. A PHYSICAL THERAPIST OFFERING TO PROVIDE OR PROVIDING "DRY NEEDLING" INTERVENTION SHALL PROVIDE DOCUMENTED PROOF OF COMPLIANCE WITH THE QUALIFICATIONS LISTED IN PARAGRAPH (C) TO THE BOARD WITHIN 30 DAYS OF COMPLETION OF THE COURSE CONTENT IN PARAGRAPH (C) OR WITHIN 30 DAYS OF INITIAL LICENSURE AS A PHYSICAL THERAPIST IN ARIZONA.

C. COURSE CONTENT THAT MEETS THE TRAINING AND EDUCATION QUALIFICATIONS FOR "DRY NEEDLING" SHALL CONTAIN ALL OF THE FOLLOWING:

1. THE COURSE CONTENT SHALL BE APPROVED BY ONE OR MORE OF THE FOLLOWING ENTITIES PRIOR TO THE COURSE(S) BEING COMPLETED BY THE PHYSICAL THERAPIST.

a. COMMISSION ON ACCREDITATION IN PHYSICAL THERAPY EDUCATION,

b. AMERICAN PHYSICAL THERAPY ASSOCIATION,

c. STATE CHAPTERS OF THE AMERICAN PHYSICAL THERAPY ASSOCIATION,

d. SPECIALTY GROUPS OF THE AMERICAN PHYSICAL THERAPY ASSOCIATION, OR

e. THE FEDERATION OF STATE BOARDS OF PHYSICAL THERAPY.

2. THE COURSE CONTENT SHALL INCLUDE THE FOLLOWING COMPONENTS OF EDUCATION AND TRAINING:

a. STERILE NEEDLE PROCEDURES TO INCLUDE ONE OF THE FOLLOWING STANDARDS:

i. THE U.S. CENTERS FOR DISEASE CONTROL AND PREVENTION, OR

ii. THE U.S. OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION

b. ANATOMICAL REVIEW,

c. BLOOD BORNE PATHOGENS

d. CONTRAINDICATIONS AND INDICATIONS FOR "DRY NEEDLING",

3. THE COURSE CONTENT REQUIRED IN PARAGRAPH (C) OF THIS SECTION SHALL INCLUDE, BUT IS NOT LIMITED TO, PASSING OF BOTH A WRITTEN EXAMINATION AND PRACTICAL EXAMINATION BEFORE COMPLETION OF THE COURSE CONTENT. PRACTICE APPLICATION COURSE CONTENT AND EXAMINATIONS SHALL BE DONE IN PERSON TO MEET THE QUALIFICATIONS OF PARAGRAPH C.

4. THE COURSE CONTENT REQUIRED IN PARAGRAPH (C) OF THIS SECTION SHALL TOTAL A MINIMUM OF 24 CONTACT HOURS OF EDUCATION.

D. THE STANDARD OF CARE FOR THE INTERVENTION "DRY NEEDLING" INCLUDES, BUT IS NOT LIMITED TO THE FOLLOWING:

1. "DRY NEEDLING" CANNOT BE DELEGATED TO ANY ASSISTIVE PERSONNEL.

2. CONSENT FOR TREATMENT FOR THE INTERVENTION "DRY NEEDLING" IS THE SAME AS REQUIRED UNDER A.A.C. R4-24-301.

3. DOCUMENTATION OF THE INTERVENTION "DRY NEEDLING" SHALL BE DONE IN ACCORDANCE WITH A.A.C. R4-24-304.

In addition to the above changes, A.A.C. R4-24-208 will be updated to require all physical therapists to state on their license renewals if they have completed Dry Needling training in accordance with the above standards.

Arkansas:

Approved

Board

May 28 2009

PT Board minutes from May 28 2009 state that DN is in the scope of practice for PTs. After receiving a cease letter from an Acupuncture Safety group in 2014, the Board reaffirmed that their previous acceptance of DN in 2009 was still standing.

Source 1: AR State Board of Physical Therapy MINUTES May 28 2009, page 2
Michael DuPriest, PT emailed asking if dry needling is within the scope of practice. This issue was discussed at the February meeting and the Board determined further information was needed. Additionally information was received from Michael DuPriest but his question in the second email was regarding needle EMG. The Board determined previously that EMGs are within the scope of practice. Clarification was received from Michael DuPriest and the Board determined dry needling is within the scope of practice.

California:

Not Allowed

No further information or sources.

Colorado:

Allowed with Requirements

Per the Board

The Board states that DN is within the scope of practice of a PT but that PTs must be properly educated in order to perform DN. This education must consist of at least 46 hours of in-person dry needling training.

Source: Colorado Code

211. Requirements for Physical Therapists to Perform Dry Needling

A. Dry needling (also known as Trigger Point Dry Needling) is a physical intervention that uses a filiform needle to stimulate trigger points, diagnose and treat neuromuscular pain and functional movement deficits; is based upon Western medical concepts; requires an examination and diagnosis, and treats specific anatomic entities selected according to physical signs. Dry needling does not include the stimulation of auricular or distal points.

B. Dry needling as defined pursuant to this rule is within the scope of practice of physical therapy.

C. A Physical Therapist must have the knowledge, skill, ability, and documented competency to perform an act that is within the Physical Therapist's scope of practice. Except as part of a course of study on dry needling pursuant to paragraph D.2 of this Rule, a Physical Therapist shall not perform dry needling unless competent to do so.

D. To be deemed competent to perform dry needling, a Physical Therapist must:

1. have practiced for at least two years as a Physical Therapist; and
2. have successfully completed a dry needling course of study that consists of a minimum of 46 hours of in-person (i.e. not online) dry needling training.

E. A provider of a dry needling course of study must meet the educational and clinical prerequisites as defined in this rule, paragraph D above and demonstrate a minimum of two years of dry needling practice technique. The provider is not required to be a Physical Therapist.

F. Physical Therapists performing dry needling in their practice must have written informed consent for each patient where this practice is used. The patient must sign and receive a copy of the informed consent form. The consent form must, at a minimum, clearly state the following information:

1. Risks and benefits of dry needling; and
2. Physical Therapist's level of education and training in dry needling; and
3. The Physical Therapist will not stimulate any distal or auricular points during dry needling.

G. When dry needling is performed, it must be clearly documented in the procedure notes and must indicate how the patient tolerated the technique, as well as the outcome after the procedure.

H. Dry needling shall not be delegated and must be directly performed by a qualified, licensed Physical Therapist.

I. Dry needling must be performed in a manner consistent with generally accepted standards of practice, including clean needle techniques, and the guidelines and recommendations of the Centers for Disease Control and Prevention ("CDC").

J. The Physical Therapist shall supply written documentation, upon request by the Board, which substantiates appropriate training as required by this Rule. Failure to provide written documentation, upon request, is a violation of this Rule, and is prima facie evidence that the Physical Therapist is not competent and not permitted to perform dry needling.

Connecticut:

Not Allowed

DN is listed as a procedure in acupuncture licensure, and PTs are not allowed to perform DN.

Source: Code

(B) Modulation and restoration of normal function in and between the body's energetic and organ systems and biochemical, metabolic and circulation functions using stimulation of selected points by inserting needles, including, trigger point, subcutaneous and dry needling, and other methods consistent with accepted standards within the acupuncture and Oriental medicine profession.

Delaware:

No Official Stance

Per Board

A discussion between the PT Board and the Attorney General stated that DN is not part of the PT license definition, and the Board has not or cannot expand the definition. For change to occur, it would have to be done legislatively.

District of Columbia

Allowed

Per Board

PTs wishing to perform DN must have sufficient training and education to ensure competence. Currently there are no hour requirements for a PT to follow, but it is recommended to receive CAPTE certification.

Source: Code

- Dry needling is an advanced procedure that requires additional training.
- A PT using dry needling must have documented proof of having sufficient education and training to ensure competence with the treatment or intervention. The Board strongly recommends completion of a board-approved or Commission of Accreditation in Physical Therapy Education (CAPTE) approved professional training program on dry needling that includes evidence of meeting expected competencies and demonstration of cognitive and psychomotor knowledge and skills, and that is not an online or self-study course, or graduate or higher level coursework in a CAPTE approved educational program, which included dry needling in the curriculum.
- The licensed PT bears the burden of proof of having sufficient education and training to ensure competence with the treatment or intervention.
- Dry needling procedures should be performed in a manner that is consistent with generally accepted standards of practice, including clean needle techniques, and other applicable standards of the Centers for Disease Control and Prevention as they may be amended or republished from time to time.
- A PT who performs dry needling procedures should obtain written informed consent from each patient that will receive dry needling, and should provide the patient with a copy of the informed consent form prior to performing the procedure.
- The informed consent form should include: the patient's signature, the risks and benefits of dry needling, the physical therapist's level of education and training in dry needling, and a clearly and conspicuously written statement that the patient is not receiving acupuncture. It should further advise the patient that acupuncture treatment, as performed by a licensed acupuncturist, might yield a holistic benefit not available through a limited dry needling treatment.
- A PT who performs dry needling procedures should maintain a separate procedure note in the patient's chart for each treatment and each note must indicate how the patient tolerate the technique as well as the outcome after the procedure.
- A PT that performs dry needling procedures must be able to produce documentation of meeting these requirements upon request by the board or an agent of the board as proof that the physical therapist is practicing within the scope of practice of physical therapy.

Florida:

Not Approved

Per Board

August 7-8 2014

The Florida Board does not find it within their power to make a rule regarding scope of practice. As such, DN is not part of their scope of practice.

Source: The Florida Board of Physical Therapy Practice Minutes
Tab 12 Dry Needling

During the May 2014 meeting The Florida Physical Therapy Association requested the opportunity to appear before the board to discuss dry needling. Representatives were present and provided information on the procedure of dry needling for the board's consideration and to initiate discussion as to whether rule development related thereto would benefit the profession.

This was placed on the agenda for further discussion.

Hongjian He, President of the Acupuncture Association and representative of the Florida State Oriental Medicine Association addressed the board. She summarized what was stated at the previous May meeting.

Anna Small, Counsel to the Florida Physical Therapy Association (FPTA), addressed the board. She believes based on 486.025 F. S. the board has the authority to set forth the scope of practice of physical therapy.

Rob Stanborough, Physical Therapist and Representative of FPTA, addressed the board. He stated the trigger points are more than pain. The [sic] can be used to manipulate the muscles. He also stated that dry needling is being used by U.S. Army physical therapists and are getting great results.

Ellen Teeter, President of the Florida State Oriental Medical Association (FSOMA) addressed the board and stated that trigger points are in fact acupoints.

Maureen Daughton, member of Sniffin and Spellman, P.A., and representing FSOMA, addressed the board. She stated that the board does not have statutory authority based on Chapter 120. By adopting a rule, the board would be in violation of this chapter.

Dr. Petraglia stated she believes a rule is a clarification of a statute and that dry needling is within the scope of practice of physical therapy.

Dr. Tasso stated what the definition of dry needling is and the definition of acupuncture. She does not believe that it is the same thing. Even though she believes that professions may overlap she does not believe dry needling is within the scope of practice per Florida statute.

Ms. Pettie stated she does not believe the board can adopt a rule based on the statute.

Dr. Petraglia stated that after discussion and hearing all sides, the board will not be moving forward with a ruling.

Georgia:

Allowed

Per Law

H.B. 505 by Rep. Sharon Cooper (R-Marietta) would change the definition of the term "physical therapy" under the Georgia Physical Therapy Act to include "examining, evaluating, and testing patients; alleviating impairments; reducing the risk of injury, impairment, activity limitations; dry needling for preventative and therapeutic purposes; instructive, consultative, educational, and other advisory services." This legislation would allow physical therapists to examine and evaluate a patient without a prior consultation with a physician. They would have 21 days or eight visits before they would have to refer a patient to a physician, and they would also have unlimited access to patients when it came time to health promotion, wellness, fitness or maintenance services under this measure. This bill was amended to require physical therapists to notify patients that their health insurers may not be required to pay for treatments that are related to their diagnosis. H.B. 505 would also expand Georgia Board of Physical Therapy's authority to regulate the practice of physical therapy by interpreting and enforcing the law and by issuing advisory opinions. MAG position: Neutral. Outcome: Passed.

Hawaii:

Not Allowed.

DN is not within the scope of practice for PTs.

Source: found at <http://www.integrativedryneedling.com/dry-needling-training/scope-of-practice/>

Physical therapists; by statute; are not allowed to puncture the skin of a patient for any purpose.

Idaho:

No Official Stance

The Board has decided to make no decision either way.

Source: found at <http://www.integrativedryneedling.com/dry-needling-training/scope-of-practice/>

Idaho has not decided to be in support of or deny Dry Needling as within the scope of Physical Therapy practice

Illinois:

Not Allowed

Per Illinois Dept. of Professional Regulation

April 26 2014

DN is not within the scope of practice for PTs.

Source: <http://www.pacificcollege.edu/news/blog/2015/04/26/pcom-proud-play-role-il-dry-needling-legislation-victory>

On April 26th, 2014, the [Pacific] College [of Oriental Medicine] received word that after thoughtful, detailed, and carefully considered review of the Acupuncture and Physical Therapy Practice Acts, the Illinois Department of Professional Regulation agreed with PCOM and coalition concerns, and determined that the practice of Dry Needling was NOT in the scope of practice of physical therapy as the acts are currently written for Illinois.

Indiana:

No Official Stance

Per INAPTA

The Indiana Chapter of the APTA has no official stance or declaration regarding DN, but chooses to adhere to the White Paper published in January of 2012 in which it is stated that DN is within the scope of PTs.

Source: <http://www.kinetacore.com/physical-therapy/Indiana/page211.html>

As of July, 2013, INAPTA does not declare a particular stance on dry needling but, rather, follows the National APTA's White Paper on Dry Needling as within the scope of practice for PTs. This document, published in January of 2021, expresses full support for physical therapists to perform dry needling.

Kansas:

Not Allowed

Per Kansas Board of Healing Arts

August 8 2010

DN is another name for acupuncture and is not part of the PT practice act.

Source: Board Minutes, as found on <http://www.integrativedryneedling.com/dry-needling-training/scope-of-practice/>

August 8 2010: Kansas Board of Healing Arts Board Minutes – C. Dry Needling: Mr. Anshutz and Mr. Riley (disciplinary attorneys of the Board of Healing Arts) stated that they believe Dry Needling is another name for acupuncture and the board only regulates acupuncture in the ND practice act. Several acupuncturists came before the board at the August 8 2010 meeting and it is expected they will go the legislature to become regulated. Dry needling does not fit any of the modalities that are included in the PT practice act and could only be included as an experimental treatment if done through one of the teaching universities and based on research.

Kentucky:

Allowed

Per Board

The board believes DN is within the scope of practice for PTs.

Source: Minutes, as found on <http://www.integrativedryneedling.com/dry-needling-training/scope-of-practice/>

The board is of the opinion dry needling is within the scope of the practice of physical therapy as defined in Kentucky law by the General Assembly at KRS 327.010(1). Dry needling is a treatment used to improve neuromuscular function. As such it falls within the definition of physical therapy as defined under KRS 327:010 (1): Physical therapy – means the use of selected knowledge and skills; invasive or noninvasive procedures with emphasis on the skeletal system; neuromuscular; and cardiopulmonary function; as it relates to physical therapy. There is nothing in KRS Chapter 327 to prohibit a licensed physical therapist from performing dry needling so long as the physical therapist is competent in performing this intervention.
Guidelines>>

Louisiana:

Allowed, with Guidelines

Per Law

DN is based upon Western medicine and not meridians or other Eastern medical practices. As such, it is not acupuncture and can be performed by PTs who have been licensed for two years and must provide documentation to the executive director of having completed a board certified course of study.

Source: Code, as found on <http://integrativedryneedling.com/resources/state-training-guidelines/#Louisiana>

Subchapter B. General Provisions

§123. Definitions

A. As used in this Title, the following terms and phrases, defined in the practice act, La. R.S.37:2401–2424, shall have the meanings specified here. Dry Needling—a physical intervention which utilizes filiform needles to stimulate trigger points in a patient's body for the treatment of neuromuscular pain and functional movement deficits. Dry Needling is based upon Western medical concepts and does not rely upon the meridians utilized in acupuncture and other Eastern practices. A physical therapy evaluation will indicate the location, intensity and persistence of

neuromuscular pain or functional deficiencies in a physical therapy patient and the propriety for utilization of dry needling as a treatment intervention. Dry needling does not include the stimulation of auricular points.

§311. Treatment with Dry Needling

A. The purpose of this rule is to establish standards of practice, as authorized by La. R.S. 37:2405 A.(8), for the utilization of dry needling techniques, as defined in §123, in treating patients.

B. Dry needling is a physical therapy treatment which requires specialized physical therapy education and training for the utilization of such techniques. Before undertaking dry needling education and training, a PT shall have no less than two years experience working as a licensed PT. Prior to utilizing dry needling techniques in patient treatment, a PT shall provide documentation to the executive director that he has successfully completed a board-approved course of study consisting of no fewer than 50 hours of face-to-face instruction in intramuscular dry needling treatment and safety. Online and other distance learning courses will not satisfy this requirement. Practicing dry needling without compliance with this requirement constitutes unprofessional conduct and subjects a licensee to appropriate discipline by the board.

C. In order to obtain board approval for courses of instruction in dry needling, sponsors must document that instructors utilized have had no less than two years experience utilizing such techniques. Instructors need not be physical therapists, but should be licensed or certified as a healthcare provider in the state of their residence.

D. A written informed consent form shall be presented to a patient for whom dry needling is being considered, telling the patient of the potential risks and benefits of dry needling. A copy of a completed form shall be preserved in the patient treatment record and another copy given to the patient.

E. Dry needling treatment shall be performed in a manner consistent with generally accepted standards of practice, including sterile needle procedures and the standards of the U.S. Centers for Disease Control and Prevention. Treatment notes shall document how the patient tolerated the technique and the outcome of treatments.

Maine:

N/A, Unknown

Maryland:

Allowed, Adopting Regulations

Per Board

January 2011

In January of 2011 the PT Board began drafting regulations on dry needling. Since then the Acupuncture Board and PT Board have met, but have yet to complete a document amenable to both parties.

Source: Letter from Steve Kaufman, L.Ac and Board Chair, to Secretary Sharfstein of the Maryland Department of Health and Mental Hygiene found on <http://dhmh.maryland.gov/docs/Letter%20from%20Steve%20Kaufman,%20Board%20Chair%20of%20Acupuncture.pdf>

Dear Secretary Sharfstein:

The Board of Physical Therapy Examiners (PT Board) has provided the Board of Acupuncture (Acupuncture Board) with a second draft of their proposed regulations on “dry needling” that we understand is currently under your review. We would like to provide you with our comments before the proposed regulations are sent to AELR and published so that our concerns may be addressed as soon as possible. Just to clarify, our understanding of dry needling is needling on trigger points to treat muscle pain.

The two Boards met in March to discuss the original draft and our concerns with several aspects of their proposed regulations. We had an informative and collegial discussion regarding their proposal, and provide several suggested changes both in writing and in the meeting. They appeared to have understood our concerns and agreed to redraft their proposed regulations accordingly. We emphasized that our recommendations were to assure that patients receive safe, effective, and appropriate care, whether from a fully-trained acupuncturist or a physical therapist using acupuncture needles. Unfortunately, most of our key concerns are not addressed in the revised proposed regulation, and would result in inadequate oversight of the profession.

Since inserting needles into a person is unlike any technique that PTs are trained in, expanding the PT scope of practice to include needling must ensure that the PT is adequately trained and monitored. This can only be done with regulations that set an appropriate level of training, supervision, and a monitoring system. The proposed regulations fall short in all of these areas. The proposed training requirements would allow courses that the PT’s have already taken in their PT training to count towards their training to do “dry needling,” even though nothing in PT coursework provides preparation for using acupuncture needles, placing needles in deep anatomical structures of the body, recognizing risk factors, mitigating any possible adverse results, or practicing clean needle technique.

Massachusetts:

Unknown

Michigan:

Not Allowed

Per Attorney General and Board

April 16 2013

DN is not within the scope of practice for PTs.

Source: Michigan Board of Physical Therapy Approved Minutes April 16 2013
Marian requested clarification of the minutes [from January 15, 2013], as to whether or not there would be additional advice from the Attorney General’s (AG) Office regarding “Dry Needling.” Mitchell informed that there will be no further advice issue from the AG’s Office, as the outcome remains unchanged. Dry Needling is not within the scope of practice of physical therapy.

Minnesota:

No Official Stance

Per Board

The Minnesota board refers to the APTA research on dry needling but makes no official statement on the issue.

Source 1: from MNPTA

MNPTA does not have an official stance on the practice of dry needling. APTA has compiled a comprehensive educational resource paper addressing dry needling, which is available to download.

Source 2: from Kinetacore website

The MN PT practice is silent on dry needling. The Board is prohibited from issuing advisory opinions or position statements, as that would be considered unpromulgated rulemaking.

Mississippi:

Allowed, with Guidelines

Per Board

September 10 2012

DN is within the scope of practice for PTs, but PTs must be adequately trained and educated before performing DN.

Source 1: Letter from Jim Hood, the Attorney General, to Debbie Moore DC, Lac dated September 2012, from page 2:

The practice guidelines for intramuscular manual therapy (dry needling) were adopted by the Mississippi State Board of Physical Therapy on September 10 2012. These regulations are found in Part 3101 Rule 1.3 (c) (A-K):

c. Intramuscular manipulation may be performed by a licensed physical therapist who has met the criteria described hereunder:

A. Intramuscular manual therapy is a physical intervention that uses a filiform needle no larger than 25 gauge needle to stimulate trigger points, diagnoses and treat neuromuscular pain and functional movement deficits; is based upon Western medical concepts; requires an examination and diagnosis, and treats specific anatomic entities selected according to physical signs. Intramuscular manual therapy does not include the stimulation of auricular or distal points or any points based upon areas of Eastern (Oriental) medicine and acupuncture.

B. Intramuscular manual therapy as defined pursuant to this rule is within the scope of practice of physical therapy.

C. A physical therapist must have the knowledge, skill, ability, and documented competency to perform an act that is within the physical therapist's scope of practice.

D. To be deemed competent to perform intramuscular manual therapy a physical therapist must meet the following requirements:

1. Documented successful completion of a intramuscular manual therapy course of study; online study is not considered appropriate training.

a. A minimum of 50 hours of face-to-face IMS/dry needling course study; online study is not considered appropriate training.

b. Three years of practice as a licensed physical therapist prior to using the intramuscular manual therapy technique.

2. The physical therapist must have Board approved credentials for providing intramuscular manipulation which are on file with the Board office prior to using the treatment technique.

E. The provider of the required educational course does not need to be a physical therapist. A intramuscular manual therapy course of study must meet the educational and clinical prerequisites as defined in this rule, D(1)(a)&(b) and demonstrate a minimum of two years of intramuscular manual therapy practice techniques.

F. A physical therapist performing intramuscular manual therapy in his/her practice must have written informed consent for each patient where this technique is used. The patient must sign and receive a copy of the informed consent form. The consent form must, at a minimum, clearly state the following information.

1. Risks and benefits of intramuscular manual therapy.
2. Physical therapist's level of education and training in intramuscular manual therapy.
3. The physical therapist will not stimulate any distal or auricular points during intramuscular manual therapy.

G. When intramuscular manual therapy is performed, this must be clearly documented in the procedure notes and must indicate how the patient tolerated the technique as well as the outcome after the procedure.

H. Intramuscular manual therapy shall not be delegated and must be directly performed by a qualified, licensed physical therapist.

I. Intramuscular manual therapy must be performed in a manner consistent with generally accepted standards of practice, including but not limited to, aseptic techniques and standards of the center for communicable diseases.

J. Failure to provide written documentation of appropriate educational credentials is a violation of this rule, and is prima facie evidence that the physical therapist is not competent and not permitted to perform intramuscular manual therapy.

K. This rule is intended to regulate and clarify the scope of practice for the physical therapist.

Missouri:

No Official Stance

Per Board

February 25 2014

DN is not yet part of the scope of practice of PTs in Missouri, but the board would like to make it.

Source 1: Letter from the Acupuncture Association of Missouri

On behalf of the Acupuncture Association of Missouri, we would like to vehemently urge you not to adopt new regulations that would expand the scope of practice of physical therapists to include the practice of "dry needling."

"Dry needling," which utilizes acupuncture needles inserted through and beneath the skin and into the tissues below, is a modality of therapy that is neither different nor unique from acupuncture. It is a newly constructed phrase intended to obfuscate and mislead on a broad scale. This is not only a gross misinterpretation, but an actual falsehood. "Dry needling" utilizes the same tools as acupuncture (acupuncture

needles) and goes into the same bodily tissues as acupuncture. These bodily tissues do not recognize a difference between “acupuncture,” “dry needling” or “intramuscular therapy” for a very simple reason: because there is none. The real difference lies in who administers acupuncture and whether they are properly trained and qualified to do so. We contend that physical therapists are neither properly trained nor qualified.

Licensed acupuncturists receive hundreds of classroom hours relevant to the practice of acupuncture: anatomy, physiology, point location, and needling techniques. Furthermore, they receive hundreds of hours of clinical supervision on the practice of acupuncture in which they observe and receive supervised practice with advanced practitioners of acupuncture techniques. This level of didactic education and hands-on mentorship and training is not replaceable by other less intensive formats. And the subsequent level of knowledge and skill that a licensed acupuncturist has after this is not replicable without this level of education. After this extensive education, licensed acupuncturists also take a national board exam proctored by the NCCAOM in order to obtain licensure at the state level. To assume any comparable level of knowledge and skill between a licensed acupuncturist and a physical therapist is not only absurd, but dangerous.

With the rise in “dry needling” by non-licensed acupuncturists there has also been an alarming occurrence of dangerous conditions, including pneumothorax (the collapsing of the lung due to puncture). Perhaps even more alarming than this injury is that there have been cases of pneumothorax in which these less qualified practitioners did not even recognize the symptoms or severity of this injury in order to advise the patient to receive emergency care. For these patients, the injuries have been debilitating and disabling.

As licensed acupuncturists, our interest is in providing safe and effective acupuncture to promote the health and well-being of our communities. It is against our ethical and professional principles to stand off to the side of this critical issue knowing that it jeopardizes the health and safety of the people we study so long and hard to serve.

*Source 2: Missouri Physical Therapy Association Board of Directors Meeting
February 25 2014, page 2:*

(2) Discussion regarding dry needling in some states and we need to be aware. Dry needling will be in the guide and should assist in moving forward in the practice. Looked at not a basic skills for school at this time for education.

(8) Dry needling—consult with board of healing arts—can’t do invasive tests but dry needling isn’t invasive; it is a continuing education activity to be able to do so using the training to be able to do. We may need to get dry needling defined and/or add to practice act or added on the acupuncture rules as qualified to perform. We don’t usually list everything we do in the practice act and rules.

*Source 3: Missouri Physical Therapy Board of Directors Meeting, April 11 2014,
page 1.*

Dry Needling – Concerns /issues. Does the Board need to take action or continue to monitor? There are 45 schools teaching dry needling in school maybe as a special presentation without competencies assessed. May need to add to our practice act or go the acupuncturists about adding PT to their practice act to allow doing it in Missouri.

Montana:

Allowed

Per Board

May 14 2015

DN is within the scope of PT and is distinct from acupuncture.

Source: Board Minutes May 14 2015, page 532-3

NEW RULE I DRY NEEDLING (1) Dry needling is a manual therapy technique that uses a filiform needle as a mechanical device to treat conditions within the scope of physical therapy practice.

- (a) It is based upon Western medical concepts, requires a physical therapy examination and diagnosis, and treats specific anatomic entities.
 - (b) Dry needling does not include the stimulation of auricular or distal acupuncture points or acupuncture meridians.
- (2) Licensed physical therapists performing dry needling must be able to demonstrate they have received training in dry needling that meets the standards of continuing education as set forth by the board's continuing education rules.
- (a) Dry needling courses must include, but not be limited to, training in indications, contraindications, potential risks, proper hygiene, proper use and disposal of needles, and appropriate selection of clients.
 - (b) Initial training in dry needling must include hands-on training, written examination, and practical examination.
- (3) A licensed physical therapist must perform dry needling in a manner consistent with generally accepted standards of practice, including clean needling techniques, relevant standards of the Centers for Disease Control and Prevention, and Occupational Safety and Health Administration blood borne pathogen standards as per 29 CFR 1910.1030, et. seq.
- (4) Dry needling may only be performed by a licensed physical therapist and may not be relegated to a physical therapist assistant.
- (5) The physical therapist performing dry needling must be able to provide written documentation, upon request by the board, which substantiates appropriate training as required by this rule. Failure to provide written documentation may result in disciplinary action.
- (6) No physical therapist shall advertise or in any way hold themselves out as an acupuncturist, unless that physical therapist is a licensed acupuncturist under the provisions of Title 37, chapter 13, MCA.

REASON: The board is proposing to adopt this new rule to provide guidance on the practice of dry needling within the scope of physical therapy. The scope of practice of physical therapists is broad and includes the use of mechanical devices, such as filiform needles, to treat physical disability, bodily malfunction, pain, and injury. The Federation of State Boards of Physical Therapy (FSBPT) reports that research supports the use of dry needling to improve pain, reduce muscle tension, and facilitate speedier rehabilitation.

The board formed a joint committee with the Board of Medical Examiners (BME) to investigate the safety, efficacy, educational standards, and uses of dry needling in physical therapy and the overlap with the practice of acupuncture, which is under the jurisdiction of BME. Acupuncturists and the Montana Association of

Acupuncture and Oriental Medicine oppose dry needling with the scope of physical therapy practice. The BME determined they have no authority over physical therapists or their scope of practice.

The training for and application of dry needling in physical therapy, not the use of a needle, distinguishes dry needling from acupuncture. Acupuncture meridians and auricular or distal acupuncture points are not part of dry needling.

The board is proposing this new rule now because physical therapists in Montana are incorporating dry needling into their practices. Public safety is the foremost concern of the board. This new rule establishes criteria for the inclusion of dry needling within the scope of physical therapy, ensures that physical therapists practicing dry needling meet demonstrable educational, training, and safety standards, and sets consequences for failing to meet those standards.

Nebraska:

Allowed, with Guidelines

Per Board

DN is allowed for PTs with proper training

Source: Nebraska State Board of Health Meeting Minutes for March 23 2015, page 4
UNFINISHED BUSINESS: Dry Needling. There was discussion to drop this item off of the Unfinished Business agenda, or reinstate it. Dr. Vander Broek made a motion to resurrect the original letter. No second was made, so the motion died. There was a question about the Attorney General Opinion. Kevin Griess will follow up on the letter from last year.

Nevada:

Allowed

Per Board

February 2012

DN is within the PT scope of practice.

Source: "Opinion Regarding the Performance of Dry Needling and the Practice of Physical Therapy," from May 25 2012, page 1-2

On October 2, 2008, the Board was asked to address a recent decision made by the ACCE wherein the ACCE had decided to deny approval for a continuing education course on the topic of Dry Needling (hereinafter, "DN".) After exploring the issue, the Board ultimately upheld the decision of the ACCE and concluded that the denial of credit would stand since DN was not considered by the Board to be within the scope of physical therapy practice in the State of Nevada.

In February 2012, the Board received a petition for a declaratory order from one of its licensees pursuant to NAC 640.310, asking that the Board consider and reverse its decision of October 2, 2008 to conclude that DN was, in fact, within the scope of physical therapy practice in the State of Nevada. On March 20, 2012 the Board considered the petition in question and ultimately granted it. ***Thus, the Board will now deem DN to be within the scope of practice of physical therapy in the State of Nevada.***

Factual Introduction

...it is important to distinguish DN from the ancient practice of acupuncture within traditional Chinese medicine. At a basic level, both procedures involve the insertion of needles to alleviate pain, yet there are also some important differences which distinguish each procedure. Acupuncture arises from and is grounded in ancient rules and theories, while DN is solely based upon modern scientific neurophysiology, anatomy and newer understandings within the discipline of pain science. Additionally, the overall purpose of DN is strictly to provide pain control in the musculoskeletal system while acupuncture is used to address a range of illnesses, other than just pain relief. Furthermore, acupuncture involves the insertion of needles into specific named acupuncture points, which may or may not overlie muscles and 'trigger points.' Thus, acupuncture will always remain a viable treatment option for a range of disorders and pain issues. To be clear, however, the present declaratory order is limited strictly to DN and not acupuncture.

New Hampshire:

Allowed

Per Board

March 1 2002

DN is within the scope of PT practice but ought to be performed only by competent individuals.

Source 1: Letter dated March 1 2002 from the Office of Allied Health Professionals
Please be advised that dry needling is considered in the scope of practice for physical therapy. However, the Governing Board would like to stress that one should never practice procedures beyond their personal competency, and specific training is strongly recommended.

As the course offering for this particular procedure is unknown, the Governing Board is recommending that it be sanctioned otherwise credentialed by a nationally recognized standard, i.e. APTA, FSBPT. Upon completion, you should be given a certificate with the course name that is signed and dated, attesting to your successful participation.

Source 2: PT Governing Board Minutes October 19 2011, page 2

c. Are PTs and PTAs allowed to do "dry needling?" A PT or PTA can do "dry needling" if they have been trained to do so.

Source 3: PT Governing Board Minutes May 15 2013, page 5

14. Dry Needling – The Board reviewed numerous documents describing dry needling, various techniques, and the educational requirements. The Board made the following determination on a motion from Martha Aguiar with a second by Robert Brunton; It is this Boards opinion that it is not within the scope of practice for a physical therapist assistant to perform dry needling.

New Jersey:

Not Allowed

Per BME

The BME definition of acupuncture makes it so that DN is in actuality acupuncture, and as such cannot be performed by any individuals who are not licensed acupuncturists.

Source: "Dry Needling" by Physical Therapists as Unlicensed Acupuncture in New Jersey: A Chronological Review" by the New Jersey Association of Acupuncture and Oriental Medicine.

The New Jersey State Board of Medical Examiners (the "BME") recognizes that the use of needles done by non-physicians for medical treatment and pain control constitutes the practice of acupuncture. The BME defines "acupuncture" as "the stimulation of a certain point or points on or near the surface of the body by the insertion of special needles to prevent or modify the perception of pain or to normalize physiological functions including pain control and for the treatment of certain diseases and dysfunctions of the body." The BME further states that use of "needles" to stimulate acupuncture points and channels shall be performed only by acupuncturists certified or approved by the BME. (N.J.A.C. 13:35-9.2; 13:35-9.12) Thus, dry needling, as practiced by non-physicians including physical therapists, constitutes the practice of acupuncture as defined by the BME and is subject to the BME's requirements.

New Mexico:

Allowed

Per Board

March 21 2000

There is nothing in the practice act prohibiting DN.

Source: found at <http://www.integrativedryneedling.com/dry-needling-training/scope-of-practice/>

March 2000: In a letter dated March 21 2000; the PT board determined that the PT Act does not prohibit dry needling and that Section 61-12D-3: Paragraph I: Number 2 – describing the practice of physical therapy supports that decision.

New York:

Not Allowed

Per State

2007

DN is an advanced skill that is not for PTs.

Source: found at <http://www.integrativedryneedling.com/dry-needling-training/scope-of-practice/>

Affirmed in 2007 NY State Board issued an opinion in early 1990s that it was not an entry level skill and therefore could not be done.

North Carolina:

Allowed, with Guidelines

Board

October 30 2013

According to the board, DN and acupuncture are different procedures and it is within the scope of practice for a PT to perform DN.

Source 1: Position Statement: NC Board of Physical Therapy Examiners
Intramuscular Manual Therapy
Approved September 23, 2010
Revised - December 9, 2011
Revised- June 14, 2012
Revised- June 19, 2014 - (Programs approved by NCBPTE added Sept 13, 2012, Dec 6, 2012, July 30, 2013, Aug 28, 2013, Oct 22, 2013, and Oct 30, 2013)

Definition: Intramuscular Manual Therapy (IMT), which is generally referred to as dry needling, is defined as a technique to treat myofascial pain using a dry needle (without medication) that is inserted into a trigger point with the goal of releasing / inactivating the trigger points and relieving pain.

Intramuscular manual therapy is not Acupuncture, which is defined by NCGS § 90-451 (1) as follows: *"A form of health care developed from traditional and modern Chinese medical concepts that employ acupuncture diagnosis and treatment, and adjunctive therapies and diagnostic techniques, for the promotion, maintenance, and restoration of health and the prevention of disease."*

Distinction between Acupuncture and IMT (Dry Needling)

Acupuncture is based on traditional Chinese medical concepts and modern oriental medical techniques, while dry needling is described in **Physical Therapists & the Performance of Dry Needling, a Resource Paper** published by the American Physical Therapy Association (APTA) in January, 2012, as insertion by dry needle into a trigger point without medication or injection. A trigger point is a taut band of skeletal muscle, which can be tender and refer pain to distant parts of the body.

Physical therapists use dry needling to release / activate the trigger points and relieve pain, while acupuncture includes diagnostic techniques for the restoration of health and prevention of disease.

Position Statement

Intramuscular Manual Therapy (Dry Needling)

June 19, 2014 (Educational Programs approved by NCBPTE added Sept 13, 2012, Dec 6, 2012, July 30, 2013, Aug 28, 2013, Oct 22, 2013, and Oct 30, 2013)

Background: In 2002, the Board was asked whether dry needling was within the scope of practice for physical therapists. At that time, there was very little research published about the use of dry needling or evidence that supported the practice of dry needling by physical therapists. However, since the definition of physical therapy in the North Carolina Physical Therapy Practice Act and the Board's rules contemplates modifications to the scope of practice of physical therapy as practitioners become proficient in new patient treatment techniques, it is appropriate for the Board to periodically revisit its Position Statements to determine if scope of practice developments warrant revisions to the Position Statements.

Since 2002, there have been significant developments in the use of Intramuscular Manual Therapy in physical therapy practice. According to the "Intramuscular Manual Therapy (*Dry Needling*) Resource Paper" published by the Federation of State Boards of Physical Therapy (FSBPT) on March 8, 2010, *"there are numerous scientific studies to support the use of dry needling for a variety of conditions"* and many of the studies have been conducted by physical therapists. Additionally, in 2002, there were very few states that allowed dry needling; however, as the scope of practice of physical therapy has evolved, at least 23 other states and the District of Columbia (*including neighboring jurisdictions of Virginia, Tennessee, South Carolina, Georgia, Maryland, Kentucky, and DC*) have issued opinions that Intramuscular Manual Therapy is within the scope of practice of physical therapists. With increased mobility within the profession, there are a number of North Carolina licensees who are skilled in Intramuscular Manual Therapy techniques, and have lawfully utilized those techniques in other jurisdictions.

Scope of Practice:

NCGS: 90-270.24. Definitions.

(4) "Physical Therapy" means the evaluation or treatment of any person by the use of physical, chemical, or other properties of heat, light, water, electricity, sound, massage, or therapeutic exercise, or other rehabilitation procedures, with or without assistive devices, for the purposes of preventing, correcting, or alleviating a physical or mental disability. Physical therapy includes ... administration of specialized therapeutic procedures. Evaluation and treatment of patients may involve physical measures, methods, or procedures as are found commensurate with physical therapy education and training and generally or specifically authorized by regulations of the Board. ..."

21 NCAC 48C .0101 PERMITTED PRACTICE

(a) Physical therapy is presumed to include any acts, tests, procedures, modalities, treatments, or interventions that are routinely taught in educational programs or in continuing education programs for physical therapists and are routinely performed in practice settings.

Position Statement

Intramuscular Manual Therapy (*Dry Needling*)

June 19, 2014 (*Educational Programs approved by NCBPJE added Sept 13, 2012, Dec 6, 2012, July 30, 2013, August 28, 2013, Oct 22, 2013, and Oct 30, 2013*)

Practice Developments: Information furnished to the Board indicates that Intramuscular Manual Therapy is routinely taught in continuing education programs and is routinely performed in practice settings. According to the previously referenced FSBPT Resource Paper, *"It appears that there is a historical basis, available education and training as well as an educational foundation in the CAPTE criteria, and supportive scientific evidence for including intramuscular manual therapy in the scope of practice of physical therapists. The*

education, training and assessment within the profession of physical therapy include the knowledge base and skill set required to perform the tasks and skills with sound judgment. It is also clear; however, that intramuscular manual therapy is not an entry level skill and should require additional training." On October 17, 2009, the Executive Committee of AAOMPT (*American Academy of Orthopedic Manual Physical Therapists*) adopted an official position statement that "dry needling is within the scope of physical therapist practice." The APTA's Guide Revision Expert Panel has recommended that dry needling be included in the Guide to Physical Therapist Practice (3rd Edition). The question of whether the insertion of a needle would be "an invasive procedure that is not allowed for physical therapists" is not an issue in North Carolina as physical therapists have used needle insertion for EMG studies for more than forty years.

Position: Based on currently available resource information, it is the position of the North Carolina Board of Physical Therapy Examiners that Intramuscular Manual Therapy (Dry Needling) is within the scope of practice of physical therapists. Intramuscular Manual Therapy is an advanced skill that requires additional training beyond entry-level education and should only be performed by physical therapists who have demonstrated knowledge, skill, ability, and competence as follows: Completion of an Intramuscular Manual Therapy course of study at a program approved by the Board* with a minimum of 54 hours of classroom education, which must also include instruction in the clinical application of iMT (Dry Needling). Since Intramuscular Manual Therapy requires ongoing re-evaluation and reassessment, it is not in the scope of work for physical therapist assistants or physical therapy aides.

*** PROGRAMS THAT HAVE BEEN APPROVED BY THE BOARD (Updated -10-22-13)**

1. Myopain Seminars
2. Kinetacore Physical Therapy Education
3. Joseph Donnelly, PT, DHS, Mercer University Department of Physical Therapy
4. Dry Needling Institute -American Academy of Manipulative Therapy (AAMT)
5. Evidence in Motion (EIM)
6. Institute of Advanced Musculoskeletal Treatments (IAMT)
7. Double E PT Education
8. Dr. Ma's Dry Needling Institute for Physical Therapists LLC
9. Carolinas Rehabilitation Orthopaedic PT Residency

(Note: In developing this Position Statement, the Board sought input and materials from a variety of health care professionals, including representatives of the North Carolina Acupuncture Licensing Board,

who attended and participated in discussions regarding dry needling. Approximately two years after the Board adopted its Position Statement, the Acupuncture Licensing Board adopted its own Position Statement, which can be found on its website.)

*Source 2: Letter to Acupuncture Counsel from PT Board
December 1, 2011*

E. Ann Christian, Counsel
North Carolina Acupuncture Licensing Board
Post Office Box 10686
Raleigh, North Carolina 27605
RE: Advisory Opinion: Dry Needling
Dear Ms. Christian:

On behalf of the North Carolina Acupuncture Licensing Board, you have asked for an opinion concerning a Position Statement recently issued by the North Carolina Board of Physical Therapy Examiners (hereinafter "NCBPTE") in which it reversed its earlier position that dry needling, otherwise known as "intramuscular manual therapy," is not within the scope of practice of a physical therapist. Dry needling refers to the therapeutic effect of applying needle stimulation directly to trigger points without the use of injection. Dry needling utilizes a solid needle, such as an acupuncture needle. The Acupuncture Board's position is that this procedure is acupuncture because it utilizes the same medical tools, techniques, locations, and has the same purposes as acupuncture. You stated that the Acupuncture Board believes that the authority to insert needles is reserved, under Article 30 of Chapter 90 of the General Statutes, the North Carolina Acupuncture Practice Act, to licensed acupuncturists and certain health care professionals specifically exempted from its licensing requirements.

The authority to use acupuncture needles for therapeutic purposes is not necessarily reserved exclusively to licensed acupuncturists or those specifically exempted from the licensing requirement for acupuncturists. State law recognizes that the scope of practice of health care professions may overlap and confers extensive discretion on licensing boards to define the scope of a profession within statutory limits. In our opinion, the Board of Physical Therapy Examiners may determine that dry needling is within the scope of practice of physical therapy if it conducts rule-making under the Administrative Procedure Act and adopts rules that relate dry needling to the statutory definition of practice of physical therapy. Any such process should consider standards for education and training that presumably would be at least as strict as those set by the Legislature for physicians who use acupuncture needles for similar therapeutic purposes.

N.C. Gen. Stat. 90-451(1) defines acupuncture as "[a] form of health care developed from traditional and modern Chinese medical concepts that employ acupuncture diagnosis and treatment, and adjunctive therapies and diagnostic techniques, for the promotion, maintenance, and restoration of health and the prevention of disease." The practice of acupuncture is defined in N.C. Gen. Stat. 90-451(3) as "[t]he

insertion of acupuncture needles and the application of moxibustion to specific areas of the human body based upon acupuncture diagnosis as a primary mode of therapy. Adjunctive therapies within the scope of acupuncture may include massage, mechanical, thermal, electrical, and electromagnetic treatment and the recommendation of herbs, dietary guidelines, and therapeutic exercise."

Dry needling can utilize the same needles as acupuncture, but the technique is not based upon Chinese medical concepts. The approach of dry needling is based on Western anatomical and neurophysiological principles. Dry needling is, therefore, distinct from acupuncture. The question then becomes whether it is within the scope of practice of physical therapists to puncture the human body with a needle. N.C. Gen. Stat. 90-270.24(4) defines physical therapy as:

the evaluation or treatment of any person by the use of physical, chemical, or other properties of heat, light, water, electricity, sound, massage, or therapeutic exercise, or other rehabilitative procedures, with or without assistive devices, for the purposes of preventing, correcting, or alleviating a physical or mental disability. Physical therapy includes the performance of specialized tests of neuromuscular function, administration of specialized therapeutic procedures, interpretation and implementation of referrals from licensed medical doctors or dentists, and establishment and modification of physical therapy programs for patients. Evaluation and treatment of patients may involve physical measures, methods, or procedures as are found commensurate with physical therapy education and training and generally or specifically authorized by regulations of the Board. Physical therapy education and training shall include study of the skeletal manifestations of systemic disease. Physical therapy does not include the application of roentgen rays or radioactive materials, surgery, manipulation of the spine unless prescribed by a physician licensed to practice medicine in North Carolina, or medical diagnosis of disease.

The definition neither specifically allows nor prohibits the puncturing of the body. The NCBPTE notes, however, that the insertion of needles by physical therapists has long been accepted practice since physical therapists, with the concurrence of the NC Medical Board, insert needles in patients while conducting EMG studies. In 1995, The Board of Medical Examiners of the State of North Carolina (now North Carolina Medical Board) issued a letter in which the Medical Board stated that "In response to your request of August 30, 1994, the Board after extensive legal and medical inquiry has determined that physical therapists can perform EMG and nerve conduction studies and may make physical therapy interpretations but not medical diagnosis based on the results. It is within the scope of the licensure of physical therapists."

Thus, insertion of needles by physical therapists does not appear to be prohibited in all circumstances. In its Position Statement of September 23, 2010, the NCBPTE stated: "In 2002, the Board was asked whether dry needling was within the scope of practice for physical therapists. At that time there was very little research published about the use of dry needling or evidence that supported the practice of dry needling by physical therapists. However, since the definition of physical therapy in the North Carolina Physical Therapy Practice Act and the Board's rules contemplate modifications to the scope of practice of physical therapy as practitioners become proficient in new patient treatment techniques, it is appropriate for the Board to

periodically revisit its Position Statements to determine if scope of practice developments warrant revisions to the Positions Statements." Additionally, the Board found that "there have been significant developments in the use of intramuscular manual therapy in physical therapy practice. According to the 'Intramuscular Manual Therapy (Dry Needling) Resource Paper' published by the Federation of State Boards of Physical Therapy (FSBPT) on March 8, 2010, 'There are numerous scientific studies to support the use of dry needling for a variety of conditions' and many of the studies have been conducted by physical therapists. Additionally, in 2002, there were very few states that allowed dry needling; however, as the scope of practice of physical therapy has evolved, at least 15 other states (including neighboring jurisdictions of Virginia, South Carolina, Georgia, Maryland, Kentucky, and Washington, DC) have issued opinions that intramuscular manual therapy is within the scope of practice of physical therapists."

Disputes over the scope of practice of licensed occupations have always existed. The scopes of practice of regulated health care professions are set forth in the various sections of the North Carolina Statutes. Many of these licensing statutes presume there will be some overlap among the various professions and include a variation of the phrase "[n]othing in this Article shall be construed to prohibit any act in the lawful practice of a profession by a person duly licensed in this State." See, e.g., N.C. Gen. Stat. § 90-270.34.

In our opinion, it is within the power of the NCBPTE to determine whether dry needling is within the scope of practice of physical therapists. We note, however, that N.C. Gen. Stat. 90-270.28 empowers and requires the NCBPTE to make rules for the purpose of enabling the Board to safeguard the public health, safety and welfare against unqualified or incompetent practitioners. Since dry needling does not appear to be within the curriculum of most schools of physical therapy at this time, we believe that the NCBPTE must adopt administrative rules and standards so that dry needling is conducted only by those physical therapists who have demonstrated a specific standard of knowledge, skill, ability and competence. A "position statement" does not have the force of law. It does not provide for adequate input by the public or by other licensed practitioners and it does not provide for adequate protection of the public.

Sincerely,

Gayl M. Manthei
Special Deputy Attorney General
Mabel Y. Bullock
Special Deputy Attorney General

North Dakota:

Allowed

Per Board

May 13 2013

DN is within the scope of practice of PT.

Source: Minutes of the Annual Meeting of the North Dakota Board of Physical Therapy

Present: Board members Terry Eckmann, Dr. Doug Eggert, Dr. David Schall, Jeanne DeKrey, Reed Argent, and Dave Reiling; Executive Officer Bruce Wessman; Board Counsel Jack McDonald; North Dakota Physical Therapy Association (NDPTA) liaison Kevin Axtman; and visitor Susan Layton

Board President Reed Argent called the meeting to order at 9 AM Monday, May 13, 2013, at the Wheeler Wolf Law Firm office, 220 N. 4th Street, Bismarck, NO 58501-4004.

*Dry Needling: Discussion was held on Intramuscular Manual Therapy (Dry Needling). The Board now has no policy on this issue and in response to inquiries states only that "as with all non-entry level skills the licensee will obtain competence through continuing education prior to practicing a new skill". The Board has also reminded licensees that one of the grounds for discipline under §43-26.1-13(3), NDCC, is failing to refer a patient or client to an appropriate practitioner if the diagnostic process reveals findings that are outside the scope of a physical therapist's knowledge, experience or expertise.

FSBPT's position paper on intramuscular manual therapy was referenced and discussed. It was moved by Dave Reiling, seconded by Jeanne DeKrey and passed unanimously to adopt as Board policy that intramuscular manual therapy (dry needling) is within the scope of practice for North Dakota physical therapists.

Ohio:

Allowed

Per Board

2007

In a letter the Executive Director of the PT Board wrote in 2007 it is stated that nothing in the law prohibits a PT from performing DN.

Source: Letter dated January 5 2007

This letter is in response to your correspondence regarding whether dry needling is permitted under the Ohio Physical Therapy Practice Act.

It is the position of the Physical Therapy Section that nothing in the Ohio Physical Therapy Practice Act prohibits a physical therapist from performing dry needling.

Performance of trigger point therapy is consistent with the knowledge and skills of licensed physical therapists. As with any specialized procedure, the physical therapist must demonstrate competency in the modality.

The Section thanks you for your correspondence.....

Oklahoma:

Allowed

Per Board

January 27 2011

The board agreed that trigger point dry needling is the practice of PTs in many states but that anything more would be acupuncture.

Source: PT Minutes from January 27 2011

The Physical Therapy Committee of the Board of Medical Licensure and Supervision met on January 27, 2011. The meeting was held at the office of the Board, 101 NE 51st Street, Oklahoma City, Oklahoma in accordance with the Open Meetings Act and the Administrative Procedures Act.

The Committee discussed dry needling. A letter and position paper from the Council of Colleges of Acupuncture and Oriental Medicine (CCAOM) on dry needling was reviewed. Their position was that dry needling is an acupuncture technique and that therapy beyond needling of trigger points is the actual practice of acupuncture. The Federation of State Boards of Physical Therapy had posted a resource on dry needling on their web site, which includes information on additional training. The Committee agreed that trigger point dry needling is part of PT practice in many states but anything beyond would be acupuncture. The item was on the agenda for information only. No further action was required.

Oregon:

Allowed, but Discouraged

Per Board

February 18 2014

The board determined that DN is not within the scope of practice for PTs.

Source: Board Statement 2014

Oregon Physical Therapist Licensing Board 2.18.14 Board Updated Statement Relevant to Physical Therapists using the Intervention of Dry Needling. On January 23, 2014 the Court of Appeals Appellate Commissioners held the opinion that dry needling is not within the scope of practice of chiropractic medicine and the recently adopted rule (OAR 811-015-0036) exceeded the scope of the Chiropractic Board's statutory authority and is invalid. At its February 18, 2014 Special Meeting the Oregon Physical Therapist Licensing Board discussed the Appellate Courts findings and has determined the Appellate Courts opinion is not applicable to the practice of physical therapy. The primary accountability of the Oregon Physical Therapist Licensing Board is public protection, rather than promotion of the profession. The Board has established professional standards of practice which help assure that physical therapists and physical therapist assistants are properly educated, hold valid/current licenses, practice within their scope of practice and continue to receive ongoing continuing competency training. The Oregon Physical Therapist Licensing Board still holds to its original opinion that dry needling of bigger points is likely within the physical therapist scope of practice (excluding PTAs). Further, the Board acknowledges that dry needling of trigger points is an advanced intervention requiring post graduate training and education. In the interest of public safety, until a measure of evidence based training and education can be determined, the Board strongly advises its licensee to not perform dry needling of trigger points. The Board, in partnership with the Oregon Physical Therapy Association, will continue to monitor National trends and legislation regarding this issue.

Source 2: Board Statement 2009

Upon further discussions the Physical Therapist Licensing Board believes that the dry needling of trigger points is likely within the physical therapist scope of practice (excluding PTAs).

The Board acknowledges that the dry needling of trigger points is an advanced intervention requiring post physical therapy graduate training and education.

Further, the Board recommends that the acupuncture committee, physical therapist and medical Boards work in partnership with their professional associations to define a minimum competency by which a physical therapist can safely practice the intervention of dry needling of trigger points.

In the interest of public safety, until training and education can be determined, the Board strongly advises its licensees to not perform dry needling of trigger points.

Pennsylvania:

Not Allowed

Per Board

DN is not within the PT scope of practice.

Source:

The State Board of Physical Therapy would like to remind you that "Dry Needling" is not currently within the scope of physical therapist practice within the Commonwealth of Pennsylvania. The Pennsylvania State Board of Physical Therapy approves many courses that relate to patient care, but are not within the scope of physical therapist practice, such as courses in radiology and surgery, in addition to dry needling. This education is approved in order to ultimately benefit patients. While dry needling is approved in some state/jurisdictions, it is not legal to perform as a physical therapist in the Commonwealth of Pennsylvania.

Rhode Island:

Allowed

Per Board

February 14 2012

DN is within the scope of practice of PT.

Source: February 14 2012 Board minutes

Board members revisited the matter of dry needling for intramuscular therapy. A board member questioned if it pertained to other professions; including Acupuncturist. The board administrator related guidance from attorney Tom Corrigan stating the use of a needle by one profession does not preclude a different profession from having a different use for a needle. Board members comment dry needling is within the scope of practice provided the licensed professional is comfortable [sic] trained and has appropriate background knowledge. For licensed physical therapists that are not qualified there are educational seminars they may sign up for and gain the required background and training.

South Carolina:

Allowed, with Caution

Per Board

October 2004

A letter from a licensed practitioner in 2004 led to the Chairperson of the board affirming that DN appears to fall within the scope of practice of a licensed PT.

June 9 2015

However, there have been recent concerns about the ability to perform dry needling in South Carolina.

Source: "Concerns about the Ability to Perform Dry Needling in South Carolina,"
posted on SCAPTA

The South Carolina Physical Therapy Association (SCAPTA) has been made aware of a number of complaints that have been filed with the South Carolina Department of Labor, Licensing & Regulation against physical therapists related to the performance of dry needling. While dry needling is within the professional and legal scope of physical therapist practice in South Carolina, there is significant concern by SCAPTA about these complaints. Complaints have been filed against both members and non-members across the state. If you or someone you know have received a complaint regarding the practice of dry needling, we need to hear from you as soon as possible.

South Dakota:

Not Recommended

per SD Board of Medical and Osteopathic Examiners

The South Dakota Board of Medical and Osteopathic Examiners consider procedures involving the breaking or altering of human tissue for diagnostic; palliative or therapeutic medical purposes to be the practice of medicine. The board determines that dry needling is significantly different from 'electromyography (EMG)' which the board previously opined was an activity within the scope of practice for a physical therapist. **Decision:** The South Dakota Board of Medical and Osteopathic Examiners determined that the procedure known as 'dry needling' does not fall within the physical therapist scope of practice as defined in SDCL ch. 36-10. This opinion issued by the Board of Medical and Osteopathic Examiners is advisory in nature. It does not constitute an administrative rule or regulation and is intended solely to serve as a guideline for persons registered; licensed; or otherwise regulated by the Board of Medical and Osteopathic Examiners.

Tennessee:

Not Recommended

Per Tennessee Attorney General

June 19 2014

The Attorney General of TN holds the opinion that DN is not in a PT's scope of practice.

Source: found at <http://www.integrativedryneedling.com/dry-needling-training/scope-of-practice/>

June 19th, 2014: The opinion of the TN Attorney General is that Dry Needling is not in a PT's scope of practice.

Texas:

No Official Position

The Texas PT Board is not legally allowed to offer advisory opinions. However, the Board has never made the determination that DN is outside the scope of practice for physical therapists. The Texas Physical Therapy Association is in favor of KinetaCore's courses.

Source: Courtney L Davenport, "Acupuncturists Sue Chiropractors for Performing Acupuncture Without Adequate Training." Published March 1 2014 on acupuncturesafety.org

Texas chiropractors are illegally performing acupuncture without enough training, "creating a significant threat to public safety and health," the Texas Association of Acupuncture and Oriental Medicine alleged in a recent lawsuit against the Texas Board of Chiropractic Examiners. (Tex. Assn. of Acupuncture & Oriental Med. v. Tex. Bd. of Chiropractic Examiners, No. D-1-GN-14-000355 (Tex., Travis Co. Dist. filed Feb. 5, 2014).)

Advocates for safe acupuncture say this is part of a disturbing trend of chiropractors and physical therapists trying to profit from performing acupuncture without understanding the science behind it.

Acupuncture has been practiced for thousands of years in Asian countries and has gained popularity in the United States over the last 15 years or so. Although its medical uses are controversial, acupuncture proponents say it restores the body's energy flow, which can relieve pain and help people recover from conditions ranging from migraines to obsessive compulsive disorder and postsurgery soreness.

Because acupuncture involves inserting long, fine needles through the skin into various trigger points, many states consider it a minimally invasive incision that can be performed by only licensed acupuncturists. States often require up to 2,000 hours of training, including hundreds of clinical training hours, before a person can be licensed. The FDA regulates acupuncture needles as class II medical devices that can be sold only to people licensed to practice acupuncture.

The Texas Occupations Code governs both acupuncturists and chiropractors. Acupuncturists are licensed by the Texas Medical Board and must complete at least 1,800 instructional hours from a reputable acupuncture school and at least two clinical rotations. The code provisions governing chiropractors prohibit incisive and surgical procedures and limit them to adjustments and manipulations to improve the musculoskeletal system. They are specifically barred from using needles except to draw blood for diagnostic testing.

But regulators have struggled with the definition of "incisive." In 1997, the Texas legislature changed the code to specify that acupuncture is a nonincisive, nonsurgical needle insertion. Although it did not change the chiropractor regulations, the state attorney general concluded that if the acupuncture rules say it is nonincisive, that must mean chiropractors can perform it. The chiropractic board adopted rules allowing members to perform acupuncture after only 100 training hours. The Texas Medical Association sued, and an appellate court eventually invalidated the board's rules allowing needle use. But the board refused to ban acupuncture, calling it a nonincisive procedure and, the acupuncture plaintiffs say, ignoring the occupation code's restriction on needle use.

“The art of acupuncture depends on full understanding of the reasons that identify where the needles should be placed. Any faulty understanding will produce disappointment for the patient and can even cause harm, leading inevitably to a loss of patient confidence in the practice of acupuncture,” said Craig Enoch of Austin, Texas, who represents the association. “The state’s regulatory obligation is not simply to protect consumers from bad practitioners, but to support consumer confidence in the industry.”

The National Center for Acupuncture Safety and Integrity (NCASI), a consumer organization that aims to protect the public, said that when acupuncture became more popular, chiropractors, physical therapists, and spas wanted to include it in their practices. But because of the licensing restrictions and training requirements, they have repackaged it as a noninvasive manual therapy.

Physical therapists (PTs) perform what they call “dry needling,” which they say is different from acupuncture because it is based on Western medicine and involves different techniques. Some states have accepted that argument and changed their regulations to allow PTs and chiropractors to perform dry needling. But NCASI and other acupuncturists—as well as a handful of states—say it is acupuncture in disguise, noting that acupuncturists are well trained in modern medical science.

“There is absolutely no difference between dry needling and acupuncture. PTs and chiropractors have tried to redefine acupuncture based on their agenda, wanting to gain access to an invasive procedure that in most states is considered the practice of medicine,” said NCASI’s executive director, Daniel Dingle. “They don’t have an accurate understanding of the historical evolution of acupuncture up to and including its use and application in modern times. They claim they’ve invented something unique.”

Dingle said dry needling can lead to pain, nerve damage, infection, or even a collapsed lung, “as has been occurring more frequently as the practice of dry needling spreads.” A Canadian Olympian in judo, Kim Ribble-Orr, had to stop competing after a massage therapist punctured her lung during a dry needling treatment, causing a deadly infection. Attorney Jeffrey Cooper of Bridgeport, Conn., recently settled a lawsuit on behalf of a woman whose right lung collapsed after an acupuncturist inserted a needle through her back into her lung. He said that although literature suggests collapsed lungs are rare, he thinks it’s an underreported complication.

“Acupuncture absolutely requires extensive training and a great deal of knowledge about not only the art of acupuncture but the human anatomy and how the two interrelate,” Cooper said. “I think it can be a safe form of alternative treatment and that it would behoove everyone—licensed practitioners and patients—to more closely regulate the practice.”

Dingle said that although health care professions are painting this as a turf war started by acupuncturists, the NCASI has no problem with them performing acupuncture as long as they are properly trained and follow safety and educational standards.

“Acupuncturists have a minimum of 1,245 hours of education plus an additional 660 hours of hands-on supervised clinical training, whereas many dry needlers have taken

only a weekend workshop,” said Dingle. “Currently, the unsuspecting public is grossly unaware of the paltry amount of training most dry needlers have.”

Utah

Allowed

Per Utah Governor Gary R Herbert

April 1 2014

The Governor of Utah signed into law HB 367 which added DN to the PT scope of practice. The Bill includes information on educational and training requirements necessary for a PT to achieve before being able to perform DN, as well as the prerequisite that any PT wishing to perform DN must already have been a licensed professional for 2 years.

Source: “Utah Legislation Includes Dry Needling in the PT Scope of Practice” published on www.apta.org April 1 2014

On April 1, Utah Governor Gary R. Herbert signed into law HB 367. The legislation amends the Utah physical therapy statute to specifically add dry needling to the physical therapist scope of practice.

“We are pleased that the Utah Chapter took this legislative action to ensure that physical therapists in the state are able to legally provide the full range interventions within the physical therapist scope of practice,” said APTA President Paul A. Rockar Jr, PT, DPT, MS. “This is a first step in the right direction to ensure that all patients have access to the care they need from their physical therapists.”

Dry needling is a skilled intervention that uses a thin filiform needle to penetrate the skin and stimulate underlying myofascial trigger points and muscular and connective tissues for the management of neuromusculoskeletal pain and movement impairments. It is recognized as being part of the legal scope of practice for physical therapists in a majority of US jurisdictions.

The legislation was sought by the Utah Physical Therapy Association (Utah Chapter) after the Utah Attorney General issued an opinion in December 2013 that dry needling was not within the legal scope of practice for physical therapists.

“We had great support from local therapists that made it very helpful working through the issues that came up with the acupuncturists, chiropractors, and physicians. In addition, our lobbyist did an amazing job; this would not have happened without his experience, contacts, and the respect he has on the hill,” said Curtis Jolley, PT, MOMT, president of the Utah Physical Therapy Association. “It was a great team effort and win for the practice of physical therapy in Utah.”

HB 367 includes language requiring that a physical therapist has held a license to practice for at least 2 years. The legislation also outlines additional education and training requirements a physical therapist must meet to perform dry needling.

The Utah Physical Therapy Association is a local chapter of the American Physical Therapy Association representing more than 800 members.

Vermont:

Stance Unclear.

Per Board
September 3 2013

Source: Board Meetings from September 3 2013

OFFICE OF PROFESSIONAL REGULATION 89 MAIN STREET, MONTPELIER, VT VERMONT BOARD OF CHIROPRACTIC APPROVED MINUTES OF SEPTEMBER 3, 2013 MEETING Present: Palmer Peet, D.C., Charles Foster, D.C., and Daniel Coane; Absent: Vernon Temple, D.C.; OPR Staff Present: Larry Novins, Peter Comart, and Diane Lafaille. 1. The meeting was called to order at 1:34 p.m. 2. The minutes of the June 4, 2013 meeting were approved as written. 3. Case Managers Report – This was tabled. 4. Other a. The Board reviewed the continuing education audits. b. The Board will discuss the possibility of putting on a continuing education seminar at future meetings. c. The following continuing education courses were reviewed: Quantum Neurology ArthroStim DVD Essentials – approved.

Functional Movement Systems – approved.

Trigger Point Therapy Course – more information is needed before a determination can be made.

Chiropractic Nutrition: Integrative Solutions for Everyday Musculoskeletal Conditions – Hours 1-5 were approved. Hour 6 was not approved. This has been approved for 5 continuing education credits total. d.

Victoria Welch sent the Board an email asking: Are Vermont Chiropractors allowed to do dry needling? The Board responded that the scope of practice of a chiropractor is set forth in 26 V.S.A. § 521-536. “Dry needling” is not addressed in the Board’s statutes or its administrative rules. The Administrative Rules mention acupuncture as an adjunctive therapy. See Rule 3.5. The Board cannot specifically address “dry needling.” All licensees, no matter what services they provide must practice within their education, training and experience.

Virginia:

Allowed

Per Board of Physical Therapy

Guidance Document 112-9 states that DN is within the scope of practice of physical therapy but should only be practiced by competent professionals. Details included below.

Source: Guidance Document 112-9 “Board of Physical Therapy Guidance on Dry Needling in the Practice of Physical Therapy”

Upon recommendation from the Task Force on Dry Needling, the board voted that dry needling is within the scope of practice of physical therapy but should only be practiced under the following conditions: Dry needling is not an entry level skill but an advanced procedure that requires additional training. A physical therapist using dry needling must complete at least 54 hours of post professional training including providing evidence of meeting expected competencies that include demonstration of cognitive and psychomotor knowledge and skills.

The licensed physical therapist bears the burden of proof of sufficient education and training to ensure competence with the treatment or intervention.

Dry needling is an invasive procedure and requires referral and direction, in accordance with § 54.1-3482 of the Code of Virginia. Referral should be in writing and specific for dry needling; if the initial referral is received orally, it must be followed up with a written referral.

If dry needling is performed, a separate procedure note for each treatment is required, and notes must indicate how the patient tolerated the technique as well as the outcome after the procedure.

A patient consent form should be utilized and should clearly state that the patient is not receiving acupuncture. The consent form should include the risks and benefits of the technique, and the patient should receive a copy of the consent form. The consent form should contain the following explanation:

Dry needling is a technique used in physical therapy practice to treat trigger points in muscles. You should understand that this dry needling technique should not be confused with a complete acupuncture treatment performed by a licensed acupuncturist. A complete acupuncture treatment might yield a holistic benefit not available through a limited dry needling treatment.

Washington:

Not Allowed

Per King County Superior Court Judge Laura Inveen

The Court found that under Washington law, the PT scope of practice does not allow dry needling.

Source: "Washington Courts Ban Physical Therapists from Practicing Dry Needling," reposted on October 16 2014 on forwardthinkingpt.com

Washington Court Injunction Bans Physical Therapists
From Practicing Acupuncture "Dry Needling":

Colorado-based training company, Kinetacore, is also enjoined from using needles in dry needling training workshops

Seattle, WA – King County Superior Court Judge Laura Inveen issued a permanent injunction against physical therapists on Friday finding that they lacked the legal authority to practice "dry needling", a term used by physical therapists who want to insert acupuncture needles into human tissue without the extensive hours of hands-on supervised training required for Licensed Acupuncturists, now called East Asian Medicine Practitioners (EAMP).

The court's ruling came in a lawsuit brought by the South Sound Acupuncture Association ("SSAA") against Kinetacore, which holds "dry needling" workshops around the country. Additional defendants included more than 20 physical therapists who had attended a Kinetacore workshop in October of 2013. The court found that under Washington law, the physical therapy scope of practice does not authorize the insertion of any type of needle, including acupuncture needles, for the purpose of

“dry needling”, and their practice of “dry needling” constitutes the unlicensed practice of medicine. The workshop was held at Salmon Bay Physical Therapy’s office in Seattle. Salmon Bay, along with the other defendants, were legally enjoined from continuing to practice dry needling.

Under the ruling, Washington State physical therapists who are outside the group specified in the Injunction, are subject to future legal action for the unauthorized practice of medicine if they perform “dry needling” and do not have a second license that allows the insertion of needles into human tissue. Two groups representing Washington acupuncturists praised the court ruling as an important public health victory and are alerting the public to be aware of any physical therapists that continue to practice “dry needling” after the judge’s ruling.

“This is a major victory for public safety. There’s a reason Washington law requires 500 hours of supervised clinical training before people are allowed to practice acupuncture” says Dan Dingle, a board member of SSAA, an Olympia-based organization that promotes education and patient safety. “When physical therapists take weekend workshops of only 27 hours and then start needling as deep as 4 inches into their patients, it’s only a matter of time before someone is seriously injured in Washington, as they have been elsewhere.”

The Washington East Asian Medicine Association (WEAMA), the state professional organization, applauds the decision. “The Legislature clearly never intended that physical therapists practice acupuncture and they are certainly not qualified to safely do so after just a weekend workshop,” says WEAMA President, Curt Eschels.

In the coming weeks, the SSAA will be seeking information from the Washington State Department of Health regarding the enforcement of the court’s ruling.

West Virginia:

Allowed

Per Opinion of the West Virginia Board of PT

July 18 2012

The Board is of the opinion that dry needling is within the scope of the practice of physical therapy as defined by West Virginia Code.

Wisconsin:

Allowed

Per PT Board

July 2009

According the 2009 Board minutes, Statute 448.50 (6) allows for ‘therapeutic intervention’ within the scope of physical therapy. Larry Nosse discussed the use of dry needling as a therapeutic technique. This process uses sterile techniques; the surface is cleaned; it does not draw blood and the physical therapists are trained in blood-body precautions. Mark Shropshire noted that the American Academy of Orthopedic and Manual Physical Therapists has made a position that DN is within the scope of practice of physical therapy. California; Nevada; Tennessee; and Florida do not allowed this technique within the scope of practice within physical therapy because these states have language noting that PTs cannot puncture the skin. **MOTION:** Otto Cordero moved, seconded by Jane Stroede

that the Board considers trigger point dry needling as within the scope of practice of physical therapy provided that the licensed PT is properly educated and trained. Motion carried unanimously.

Wyoming:

Allowed

Per Wyoming Board of PT

August 18 2009

The Wyoming Board of PT affirmed that nothing in the current practice act would preclude PTs performing DN with proper credentials.

Source: found at <http://www.integrativedryneedling.com/dry-needling-training/scope-of-practice/>

In a letter dated Aug 18 2009: the Wyoming Board of Physical Therapy affirmed that nothing in the current practice act would preclude PTs performing dry needling with proper credentials.

Dry Needling Video examples

Note: In the majority of the online videos of dry needling in dangerous areas of the body (neck, upper thorax, intercostal) the technique is identical to these sample videos and is very dangerous: rapid deep thrusting.

British Medical Journal video supplement of Doctor performing DN that results in a Pneumothorax

Text and analysis by the BMJ is in the supplementary PDFs.

While this injury is very rare, the video shows that the standard procedure of DN into muscles around organs and blood vessels is very dangerous. It is an extremely advanced technique that should be taught and performed by practitioners with years of experience. In Acupuncture Training Programs, this would only be taught in the last year of clinicals after thousands of hours of education.

<http://aim.bmj.com/content/32/6/517/suppl/DC1>

Trapezius Dry Needling Video

This video shows the typical unsafe DN technique as it is taught in Training programs.

Specifics:

1. Using oversized gloves, the practitioner is trying to isolate the belly of the trapezius in order to avoid the pleural cavity underneath. The use of gloves makes the accuracy of the isolation imperfect and more likely to lose the grip.
2. The angle and location of the needle is very dangerous when using this thrusting technique.
3. The practitioner reuses the same needle by re-inserting it through the guide tube, violating Clean Needle Technique. Once removed an acupuncture needle is non-sterile and should never be reused.

http://youtu.be/KSuX_W7qyP8

Sternocleidomastoid

Very dangerous area to needle due to carotid artery and jugular vein directly adjacent to SCM muscle. This requires extensive training with direct supervision. Proper depth of acupuncture needle insertion is 0.3-0.5 inches. Deep needling vigorous needling is prohibited.

This video shows DN training procedure needling depth of .5-1.5 inches, violating safe needle procedures.

http://youtu.be/_2opxDY8Kgc

Upper Trapezius Trigger point

Another example of dangerous needle technique.

1. Very thick .30 mm needle, inserted perpendicular to muscle body and in direction of pleural cavity and/or brachial plexus.
2. Needle technique is terrible, grasping the needle on the end and pushing directly up and down does not allow practitioner to proper control the needle direction.
3. The premise that this technique is releasing the band of muscle tension is suspect, as it is likely that the needle is striking the motor nerve insertion and stimulating a nerve conduction.

<http://youtu.be/nxFhvV9Szx8>

Trigger Point Injection Video

This is a video of TP injection, not dry needling. However, it is an example of the next step taken by PTs and others who want to further their education.

The angle and depth of the needle and technique shown is very dangerous as the needle tip was 1-2 inches into the trapezius which sits above the pleural cavity. If the patient was more slight in build, that depth of insertion would have punctured her lung.

<http://youtu.be/yEw9jBcED4w>

Promotional Video by founder of Kineticore

Note the needle technique:

1. Lack of palpation and only minor isolation of muscle group,
2. Needle is thrust up and down at wide angles to elicit twitch response,
3. Needle often bends in downstroke.

None of this type of needle technique are acceptable in Acupuncture training and practice. This man would not pass a practical acupuncture exam, yet he is the founder and most experienced practitioner of this DN training company.

<http://www.kinetacore.com/physical-therapy/media-videos/page247.html>

CCAOM Clean Needle Technique (CNT) Manual 7th Edition

Best Practices for Acupuncture Needle Safety and Related Procedures

Seventh Edition

Council of Colleges of Acupuncture and Oriental Medicine

www.ccaom.org

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The CNT Manual is intended for use primarily by state-licensed acupuncturists and students enrolled in a formal course of instruction at a school approved by the Accreditation Commission for Acupuncture and Oriental Medicine. As a statement of best practices concerning acupuncture needling and related techniques, the manual may also be beneficially used by state-licensed healthcare professionals in other disciplines who have acupuncture and related modalities within their lawful scope of practice and by acupuncturists outside the United States who are appropriately authorized to practice acupuncture within their respective national jurisdictions. The manual is not intended for use by persons without formal training and regulatory authorization to practice acupuncture. The manual focuses on safety and is not a guide to appropriate treatment for particular health conditions. While the manual is intended to reflect best practices as of the date of publication, opinions as to best practices may differ and change over time. Ongoing study and debate concerning best practices within the academic and practitioner communities is encouraged. The Council assumes no liability for any injury that may occur as a result of a practitioner's use of, or reliance upon, any safety protocol contained in this manual.

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Preface

The profession of acupuncture and Oriental medicine (AOM) in the United States continues to grow and evolve. As part of this evolution, practitioners are providing acupuncture services in hospitals, integrated medical centers, and teaching clinics. As more acupuncturists provide care in this complex array of integrated settings, the need for evidenced-based best practices in safety is essential. Acupuncture education in the U.S. has evolved to meet this challenge. Accordingly, AOM institutions that have achieved accreditation or accreditation candidacy status with the Accreditation Commission for Acupuncture and Oriental Medicine (ACAOM) continue to expand their curriculum to meet the changing needs of the profession, including coursework in bioscience, evidence-based practice, risk management, and safe clinical practices.

The information available from the Centers for Disease Control and Prevention (CDC), the Occupational Safety and Health Administration (OSHA), as well as state and local health departments, has also evolved since the release of previous editions of the *Clean Needle Technique Manual*. Changing epidemiological patterns, changes in what is considered best practices in clean and aseptic technique, and changes in technology have all contributed to improving clinical safety. What has not changed is the need for acupuncturists to apply Clean Needle Technique scrupulously as safety remains a critical aspect of clinical practice.

The purpose of the *Clean Needle Technique Manual* has also evolved. The first edition of the manual was one of the few English language sources covering safe practice standards for acupuncturists. AOM educational institutions now have a range of resources and an accreditation mandate to cover bloodborne pathogens, safe practice, emergency procedures, risk management, and safety protocols in their curricula. Information provided in the *Clean Needle Technique Manual* has also spread globally, promoting better safety standards worldwide.

Needling and other related acupuncture procedures are carried out in a unique manner where needles may be placed into tissue and removed, or may be placed into tissue and reside for a period of time before their removal. Other modalities may also be applied onto the surface of the skin and likewise be immediately removed or retained for a period of time. As such, the application of evidenced-based best safety practices takes into account the manner and timing of treatment. In developing the *Clean Needle Technique Manual*, experts from OSHA and the CDC were consulted to ensure that the recommendations in the manual meet current OSHA and CDC standards.

The *Clean Needle Technique Manual* plays an important role in preparing acupuncture students for safe practice and providing basic information required for national certification in

acupuncture by the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) and for state licensure. This manual summarizes important principles that govern safe practice suited to support the work done in introductory acupuncture technique courses in acupuncture colleges and the Clean Needle Technique course offered by the Council of Colleges of Acupuncture and Oriental Medicine (CCAOM). The information in this manual supports and contributes to the educational curricula in the areas of AOM office procedure safety, bloodborne pathogens, and risk reduction concerning acupuncture and other adjunctive therapies as practiced in private practice, conventional and CAM integrated clinical settings, and in the teaching clinics in accredited AOM programs.

This latest edition of the *Clean Needle Technique Manual* has been expanded, updated, and exhaustively reviewed. While every effort has been made to ensure that up-to-date statistics were included with respect to adverse events arising in AOM office practices, including the small risk of spreading infectious diseases, it is important to remember that these statistics are constantly changing. Acupuncture practitioners can find updated information regarding healthcare associated illnesses on U.S. government websites, a number of which are listed in Appendix B.

Introduction

In 1984, at the request of the acupuncture profession, the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) developed guidelines and recommendations for the safe and clean practice of acupuncture. The guidelines were based on the theory and practice of safety commonly used in healthcare. Conscientious use of the procedures recommended and described in this manual will reduce the risk of spreading infection and accidents in the practice of acupuncture.

Increasing knowledge, along with the application of Standard Precautions, safe clinical practices, and risk management techniques, reduces the risk of a number of potential adverse events related to acupuncture practice, reduces the spread of infection, and help ensure public safety. Furthermore, from the medical, legal, and ethical perspectives, it is the practitioner's responsibility to ensure that Clean Needle Technique has been followed correctly.

In addition to general public health sources, such as the CDC, OSHA's Bloodborne Pathogens Standards, and the U.S. Public Health Service, the information in this manual has been drawn from acupuncture research throughout the world and adapted to the unique requirements and the practice of acupuncture. Thus, many of the recommendations in this manual are modifications of techniques currently in use throughout the United States in many healthcare professions. The guidelines and standards that have been developed are the result of the synthesis of East Asian and Western resources from academic, research, and clinical arenas.

This manual reflects the current understanding of best practices in the field of acupuncture clinical techniques. Best practices are defined as "activities, disciplines and methods that are available to identify, implement and monitor the available evidence in healthcare...These activities gain input mainly through four disciplines: clinical research, clinical epidemiology, health economics and health services research." (1) In this application, best practice principles are being used to limit risks associated with acupuncture clinical practices.

These practices are the basis of both the written and practical training and exam portions of the CNT course and exam offered by the Council of Colleges of Acupuncture and Oriental Medicine. Acupuncture schools and practitioners need to maintain an awareness of informational updates concerning safety in many areas of practice (including healthcare associated infections and OSHA bloodborne pathogens standards), and continually update their understanding of the best clinical practices in the field.

This manual is not meant to define standard practices or standard of care in acupuncture techniques. The term standard of care is often used synonymously with customary practice. It is

a legal term that is commonly defined as “what a minimally competent physician in the same field would do in the same situation, with the same resources.” (2)

Standards of care in medicine may also be defined as the customary practice of a particular area or locality. Acupuncture clinical practices vary by school, region, and training. Given the historically wide variety of valid, documented acupuncture clinical practices, this manual cannot be utilized to define acupuncture standard practices.

For the purposes of this manual, the following terms will be utilized to help acupuncture practitioners apply best practices to their personal practices:

Critical: This addresses the area of highest clinical risk. The protocol is considered essential for the safety of the patient and practitioner, and scientific data demonstrates that omission could constitute a serious public health risk.

Strongly Recommended: These measures are strongly supported by clinical studies that show effectiveness of the measures in reducing risk or are viewed as important by healthcare practitioners. They are considered essential measures and frequently address areas of high clinical risk.

Recommended: These measures include two types of recommendations: (1) those that are supported by highly suggestive, but perhaps less easily generalized, clinical studies in a related field, and (2) those that have not been adequately researched, but have a strong theoretical rationale indicating that they are effective for clean and safe practice. Both types of recommendations are judged to be practical to implement, but are not considered essential practice for every practitioner in every situation. Practitioners should, however, consider these recommendations for implementation into their practices.

Acupuncture procedures are performed as part of the authorized scope of practice of some other healthcare professions. Moreover, some healthcare practitioners use terminology from their own profession for therapeutic needling techniques that is indistinguishable from therapeutic needling technique in the practice of acupuncture. Trigger point dry needling, dry needling, functional dry needling, and intramuscular manual therapy fall into this category. Other healthcare providers who may use needling techniques in their practice, whether or not the providers describe these techniques as acupuncture, are subject to the same safety guidelines since the safety guidelines apply according to what tool the practitioner is using and how that tool is applied in the course of treatment. Accordingly, throughout this manual the general term “practitioner” is used inasmuch as the safety standards contained in the manual represent best practices applicable to any healthcare practitioner who uses a filiform needle or related techniques as described herein.

Practitioners, instructors, patients, and others often contact the CCAOM national office for clarification concerning the best safety techniques for acupuncture procedures.

Overview of the Sections:

- In Part I of the manual, the literature identifying the potential for infections and other adverse events and therefore the need for specific techniques and skills is reviewed as a rationale for best practices.
- In Part II, safety considerations for needling are described in detail and the precautions from Part I are repeated. The repetition is intentional as both a teaching tool and to reinforce the fact that best practices, including Clean Needle Technique basics, apply in all situations.
- In Part III, sample best practices for other AOM office procedures are discussed and the precautions from Part I repeated specifically for these practices. The procedures to limit burns associated with moxibustion apply even when different forms of moxa are utilized. Room, table and practitioner preparation are the same no matter what types of treatments are being rendered. If used as a teaching tool, this manual makes such repetition necessary and beneficial.
- Part IV details the healthcare associated infections concerning which acupuncture practitioners need to be aware, both bloodborne and contact associated infections.
- Part V discusses personnel safety practices.
- Part VI discusses cleaning of the office, equipment and laundry.
- Part VII reviews some of the important federal regulations and nationwide standards for risk reduction that apply to acupuncture practitioners.
- Part VIII contains appendices for practitioner information.

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Part I: AOM Clinical Procedures, Safety, Adverse Events (AEs) and Recommendations to Reduce AEs

Safety remains the most important consideration for all clinicians, including acupuncturists. Any clinical efficacy is potentially endangered when a clinician is not cognizant of the potential risks of a clinical procedure to the patient, patient's family, or the clinician and clinical staff. The field of acupuncture has flourished in the United States in part because acupuncturists are perceived by members of the public, state regulators, and other providers to be well trained and the practice of acupuncture to be relatively safe. In this section, commonly used acupuncture and related clinical techniques will be reviewed for their safety history along with an overview of the best practices for limiting adverse events (AEs). Details of safety protocols for acupuncture and AOM-associated clinical procedures will be given in Part II and Part III.

According to the World Health Organization (WHO): (1)

In competent hands, acupuncture is generally a safe procedure with few contraindications or complications. Its most commonly used form involves needle penetration of the skin and may be compared to a subcutaneous or intramuscular injection. Nevertheless, there is always a potential risk, however slight, of transmitting infection from one patient to another (e.g., HIV or hepatitis) or of introducing pathogenic organisms. Safety in acupuncture therefore requires constant vigilance in maintaining high standards of cleanliness, sterilization and aseptic technique.

There are, in addition, other risks which may not be foreseen or prevented but for which the acupuncturist must be prepared. These include: broken needles, untoward reactions, pain or discomfort, inadvertent injury to important organs and, of course, certain risks associated with the other forms of therapy classified under the heading of "acupuncture." Acupuncture treatment is not limited to needling, but may also include: acupressure, electro-acupuncture, laser acupuncture, moxibustion, cupping, scraping and magnetotherapy.

Finally, there are the risks due to inadequate training of the acupuncturist. These include inappropriate selection of patients, errors of technique, and failure to recognize contraindications and complications, or to deal with emergencies when they arise.

[Licensed acupuncturists in the U.S. are well-trained. As noted in the introduction to this manual, there are a number of healthcare practitioners, however, who utilize acupuncture with minimal and inadequate training.—Ed.]

This first part of the manual is a review of the medical literature detailing the safety of various acupuncture and related AOM practices along with the uncommon risks or complications that may arise from these practices. Please note that this publication does not cover the safety issues that may arise when utilizing *materia medica*, which is beyond the scope of this manual.

There are a number of acupuncture procedures for which there are very few or no studies of adverse events (AEs). Some of the studies that include AEs in their reporting are limited in their application. Using the principles of evidence-informed practices, the information presented here is the best information available at the time of publication. While there are a number of well devised and reported studies of the minimal AEs associated with acupuncture needling, better, larger studies of AEs associated with moxibustion, gua sha, tui na and other procedures are needed. When these become available recommendations for best practices in these procedures may change.

References

1. Guidelines on Basic Training and Safety in Acupuncture. World Health Organization. <http://apps.who.int/medicinedocs/en/d/Jwhozip56e/> Published 1996. Accessed December 2012.

1. Acupuncture

Safety/Adverse Events – A Review of the Literature

Acupuncture is the insertion of needles into the skin where the therapeutic effect is expected to come primarily from the act of inserting, manipulating and/or retaining the needles in specific locations. While acupuncture points may be stimulated by a variety of methods by acupuncture practitioners (needling, moxibustion, cupping, manual pressure, electrical stimulation, laser stimulation, magnets, plum blossom, bleeding, and injection therapies among others), when the primary effect is expected from the act of inserting the needle itself, this is acupuncture.

Early reviews of the literature include those by Ernst and White, and Lao who conclude: “The risk of serious events occurring in association with acupuncture is very low, below that of many common medical treatments.” (1) “Acupuncture performed by trained practitioners using Clean Needle Technique is a generally safe procedure.” (2)

Lao et al. reviewed literature covering the years 1965-1999. “Over the 35 years, 202 incidents were identified in 98 relevant papers reported from 22 countries...Types of complications included infections (primarily hepatitis from a few practitioners), and organ, tissue, and nerve injury. Adverse effects included cutaneous disorders, hypotension, fainting, and vomiting. There is a trend toward fewer reported serious complications after 1988.” (2)

It should be noted that single-use disposable sterile needles were becoming more frequent in use in the latter half of the 1980s.

White reviewed a significant body of published evidence regarding AEs associated with acupuncture offering a numerical value of AEs associated with acupuncture treatments. “According to the evidence from 12 prospective studies which surveyed more than a million treatments, the risk of a serious adverse event with acupuncture is estimated to be 0.05 per 10,000 treatments, and 0.55 per 10,000 individual patients. . . .The risk of serious events occurring in association with acupuncture is very low, below that of many common medical treatments.” (3)

Later prospective studies conclude similarly that the vast majority of adverse events are minor and require little or no treatment. Park et al. (4) studied 2226 patients over 5 weeks of acupuncture treatments and found only 99 adverse events during that time (4.5%). The most common were bleeding/bruising (2.7%) and needle site pain (2.7%).The most likely moderately severe side effect was nerve injury (0.31%) described as temporary paresthesia which disappeared within 1 week. No serious adverse events were experienced by any patients during this study.

Witt et al. (5) observed 229,230 patients receiving, on average, ten treatments for common complaints such as pain and allergies. Of these, 19,726 reported adverse events (8.6%). Common events again included bleeding/bruising (6.14%), fatigue (1.15%), headache (0.52 %), pain including pain at the site of needle insertion (1.7%), and aggravation of symptoms (0.31%). Serious adverse events included 2 cases of pneumothorax and 31 cases of nerve injury (0.014%). 31 instances of local infections at the acupuncture insertion points were reported (0.014%) and 5 systemic infections were reported. [In the Witt study, 85% of the acupuncture practitioners received only 140 hours of acupuncture-specific training and only 15% had more than 350 hours of acupuncture training.—Ed.]

In the most recent comprehensive review of adverse events associated with acupuncture, moxibustion and cupping, Xu et al. found that between 2000 and 2011 (12 years), “117 reports of 308 AEs from 25 countries and regions were associated with acupuncture (294 cases), moxibustion (4 cases), or cupping (10 cases).” (6) Serious organ and tissue injury continue to be reported but the majority of the acupuncture-associated AEs are infections. Clusters of hepatitis had been reported in the past but not a single case is reported in this period (2000-2011). Notably, the infections had changed from the past association of acupuncture with hepatitis to skin and soft tissue infections such as *Mycobacterium* including *M. tuberculosis* and *Staphylococcus spp.* This is a significant reduction in the number of infections compared to earlier reports. The authors suggested this reduction in AEs in the U.S. is likely due to the introduction of CNT course. (See page 11 of the paper.) (6)

Preventing Acupuncture Needling Adverse Events

Although rare in terms of frequency, the most common adverse events associated with acupuncture are needle site bleeding, superficial hematoma and needle site pain. Less frequently, fainting due to acupuncture, tiredness, aggravation of symptoms and broken needle are reported. Other practice issues discussed here are stuck needle and forgotten needle.

Bruising and Bleeding

Given the nature of acupuncture needling, it is difficult to prevent all bleeding and bruising. In some cases, some minimal bleeding may be expected and even beneficial. It is possible to prevent severe bleeding and hematomas. Acupuncture practitioners must be aware of the vascular anatomy of their patients. Needling should be performed such that arteries and the larger veins are avoided. Mild pressure applied after needle removal will limit most minor bleeding.

Special consideration must be given to needling of the scalp and the pinna/auricle of the ear. Due to the vascular anatomy of these structures, bleeding is more common. Acupuncturists should apply clean cotton or gauze to prevent bleeding when removing the needles in these

areas and hold that cotton against the scalp or pinna a few seconds longer than when removing needles from other body parts. Additionally, the scalp and/or pinna should be checked a second time after all needles have been removed as bleeding can become apparent after a delay due to the microcirculation in these structures.

Anticoagulant medications may increase the tendency for bruising and bleeding. Some supplements may also have this effect. Obtaining a complete medication and supplement history, and any noted side effects from their use is important information to assess the potentials for bruising or bleeding.

Safety Guidelines to Prevent Bruising, Bleeding, and Vascular Injury

Critical	<ul style="list-style-type: none"> • Avoid needling directly into arteries and major veins through anatomical knowledge. • Identify those acupuncture points which lie over or next to major vessels: <ul style="list-style-type: none"> ○ LU 9 Taiyuan (radial artery) ○ HT 7 Shenmen (ulnar artery) ○ ST 9 Renying (carotid artery) ○ ST 12 Quepen (supraclavicular artery and vein) ○ ST 13 Qihu (subclavian artery) ○ ST 42 Chongyang (dorsalis pedis artery) ○ SP 11 Jimen (femoral artery) ○ HT 1 Jiquan (axillary artery) ○ LR 12 Jimai (femoral artery and vein) ○ BL 40 Weizhong (popliteal artery)
Strongly Recommended	<ul style="list-style-type: none"> • Palpate subcutaneous structures, including major vessels, before preparing the site for insertion. • Apply caution in patients on medications or supplements that thin the blood, especially elderly patients. • To avoid superficial bleeding or hematoma, apply pressure to points after removing needles. Reexamine needled sites a second time for signs of bleeding or hematoma and if necessary, apply pressure.
Recommended	<ul style="list-style-type: none"> • Visualize surface vessels and palpate those vessels immediately adjacent to acupuncture points being needled during needle insertion.

Needle Site Pain/Sensation

Needle pain may occur as a result of a number of factors. Practitioner-related issues that may increase needling sensation include poor technique, needling sites where alcohol remains on the skin, needling into dense connective tissue such as tendons, periosteum and perimysium,

excessive needle manipulation, or needling into a nerve. Patient-related conditions that may increase needling sensation include anxiety, nervousness, and moving body parts during needle insertion. Some needle site sensation, including “heavy,” “tight,” “tingling,” or other discomfort, may be expected or desired (*de qi* response). Acupuncture practitioners should learn which sensations are expected in a *de qi* response so they can differentiate that from nerve pain. Student practitioners need to hone their skills prior to working on patients in order to limit the pain associated with poor technique. Adequate anatomical knowledge and attention to the sensations of the tissues through which a needle is proceeding is needed to avoid needling into structures that stimulate nerve pain. Practitioners should limit the amount of needle manipulation performed with a single-direction twirling motion so as to prevent subcutaneous tissue fibers and fascia from being twisted around a needle shaft beyond that needed for desired therapeutic results.

It is also common that a patient with chronic pain may develop allodynia (a painful response to a normally innocuous stimulus) or hyperalgesia (an increased response to a painful stimulus). When a patient presents with a chronic pain condition such as fibromyalgia, that patient may have an increased sense of pain from either hyperalgesia or allodynia. (7,8)

Caffeine consumption may also affect patients’ pain perceptions. Studies have found that caffeine may attenuate the individual's perception of pain during exercise (9,10) and enhance muscular strength performance. (9) Caffeine consumption may also heighten anxiety and heightened anxiety is associated with increased perception of pain. (11) An early study found that caffeine could block the electroacupuncture-induced elevation of the nociceptive thresholds. (12) Some practitioners have also reported that when patients consume caffeine before acupuncture, they may report an increase in the sensation of needle insertion, particularly in anxious patients.

Safety Guidelines to Prevent Needle Site Pain

Strongly Recommended	<ul style="list-style-type: none"> • If alcohol is used to clean the acupuncture sites, allow alcohol to dry before needling.
Recommended	<ul style="list-style-type: none"> • Visualize anatomical structures while inserting the needle and during all needle manipulation. • Palpate subcutaneous structures, including tendons, muscles and bones, before preparing the site for insertion. • Manipulate needle to <i>de qi</i> response expected of a specific point, if desired; avoid non-therapeutic pain response.

Fainting

While feeling faint or lightheaded is a possible AE of acupuncture, most studies report that more people report a sensation of faintness or lightheadedness than actually faint after needle insertion. The study by Witt et al. found that while 0.72% of patients have some sort of vegetative symptoms only 0.027% actually faint. (5) White et al. in the Survey of Adverse Events Following Acupuncture (SAFA) study reported presyncope in 93 patients but fainting of only 6 patients. (13) In the report by McPherson et al. 8 patients had symptoms of faintness but only 4 actually fainted. (14)

Many sources report that patients may experience lightheadedness or faintness more commonly during the first time they receive acupuncture, if they are nervous, if there is excessive needle manipulation, or if the patient is particularly hungry or tired prior to needle insertion. (15)

Fainting as a result of acupuncture is reported more frequently in a review of the Chinese literature (16) when compared to outcomes from studies of other countries of origin. This might be associated with strong needling stimulation of patients in a sitting position, which can cause a marked vasodilatation leading to a decrease of blood pressure. (2) Feeling faint can also be associated with more intense needle manipulation. (17)

Safety Guidelines to Prevent Fainting

Strongly Recommended	<ul style="list-style-type: none">• Place a first-time patient in the supine position with the knees slightly elevated for the first acupuncture treatment.
Recommended	<ul style="list-style-type: none">• Explain acupuncture procedure in detail and answer all questions before acupuncture needle insertion to allay concerns and nervousness.• Inform patients that they should eat 1-2 hours before acupuncture treatments.• Limit needle manipulation during the first acupuncture treatment or until clinical assessment of the patient's response to acupuncture has been established.

Stuck Needle

After a needle has been inserted, practitioners may find it difficult to rotate, lift or withdraw the needle. This is more common if a patient moves after the needle insertion, if the practitioner uses excessive manipulation or twirling of the needle in a single direction, or if the needle is inserted to the depth that it enters into the muscle layer. To manage a situation where the needle is stuck, reassure the patient if he or she is nervous and ask him or her to relax his or her muscles; then massage or lightly tap the skin around the point after which the needle should

more easily be removed. If the needle is still difficult to withdraw, ask the patient to lie calmly for a few minutes or perform another needle insertion nearby so as to relax the muscles in the area of the stuck needle. If the needle is entangled in fibrous tissue, turn it in the opposite direction from the initial needle stimulation, twirling until it becomes loosened, then withdraw the needle.

Safety Guidelines to Avoid and/or Respond to Stuck Needle

Strongly Recommended	<ul style="list-style-type: none"> Identify the recommended depth of the needle insertion for a particular point and utilize proper stimulation techniques for needles inserted below the subcutaneous level.
Recommended	<ul style="list-style-type: none"> Situate patients in an initial position where they are relaxed and not likely to need to move. Remind patients to remain still during acupuncture treatment. If a needle that was rotated in one direction becomes stuck, rotate the needle back in the opposite direction. Stimulate the area near a stuck needle with simple finger manipulation, tapping or another needle insertion; then try again to remove a stuck needle. Leave a stuck needle in place for a few minutes; then try again to remove the needle.

Failure to Remove Needles

Since 1999, prospective studies identify a small but persistent number of patients in which needles are not removed from the patient before they leave the treatment room or clinic. (5,18)

This error by practitioners may be related to distractions from patient care. Some very basic steps can dramatically decrease the occurrence of this practitioner mistake. Retained needles may be more common within the hairline, on the chest or back if there is significant hair present, on the dorsum of the scalp or neck in a patient lying supine, or in the ear due to the decreased visibility of the small needle handle when partially or fully covered by hair. Palpating areas looking for forgotten needles may increase the risk of needlestick injuries. Documenting the number of needles inserted at the time of insertion and then counting and documenting the number of needles removed at the end of a treatment will help prevent this AE. Use counting and proper documentation to check for missing needles. However, if needle counts do not match, palpation may be necessary but should be done with extreme caution.

Safety Guidelines for Needle Removal

Strongly Recommended	<ul style="list-style-type: none">Count and write down the number of needles used, including those discarded due to improper needle placement. Count the number of needles withdrawn from the patient. Confirm that the same number of needles inserted has been withdrawn and discarded.
Recommended	<ul style="list-style-type: none">Document needle counts in the patient chart.Keep used/empty needle packets in the treatment room until the end of the patient's treatment; confirm all needles removed from packaging are accounted for either by removal from the patient, discarded unused or discarded after contamination.

Aggravation of Symptoms

Aggravation of symptoms occurs as a result of acupuncture on an infrequent but consistent basis. (6,13,14,18) Aggravation of symptoms is reported both as a potential adverse event and as an intended response to treatment, known as "Menken or Mengen phenomenon," or "healing crisis." (19) Many traditional medicine techniques include deliberate aggravation of symptoms (using a hot bath to bring about diaphoresis in the case of fever, purging as a treatment for gastric distress, etc.). Practitioners need to be clear about expected outcomes when speaking with patients prior to treatments. When aggravation of symptoms includes immediate fatigue and drowsiness, patients should be warned about driving immediately after treatment. (19)

Inflammation may be an expected response to a treatment. Inflammation, including cellular responses to stimuli, may increase the inflammatory response that then brings about improvement of health. (20-23)

The role of transient inflammatory response as a healing, restorative process is widely recognized. Within the tissues, inflammatory proteins transduce intracellular signals to define cellular responses essential to carrying out the healing processes. By manipulating the inflammatory phases of the healing process, it may be possible to accelerate tissue repair functions. (22-26) Aggravation of symptoms from acupuncture may be signaling this healing response.

If an aggravation of symptoms is not the expected outcome of an acupuncture treatment, the acupuncturist should evaluate the diagnosis and treatment plan for the patient and assess whether consultation with or referral to another practitioner would be beneficial.

Safety Guidelines for Aggravation of Symptoms

Recommended	<ul style="list-style-type: none">• Inform the patient of the likely effects of acupuncture treatment.• Advise a patient that aggravation of symptoms may be a transient outcome of treatment.• If unexpected aggravation of symptoms occurs as a result of acupuncture treatment, consider consultation with or referral to another practitioner for further evaluation prior to performing additional acupuncture treatments.• Provide patients with information on acupuncture therapies including practitioner contact information in the event they have questions or concerns following treatment.
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Preventing Rare but Serious Adverse Events (SAEs) Associated with Acupuncture Needling

Pneumothorax

Pneumothorax is defined as the abnormal presence of air in the space between the lung and the wall of the chest (pleural cavity), which prevents lung expansion. Primary spontaneous pneumothorax (PSP) occurs in healthy people without a precipitating event such as lung illness or puncture. A small area on the surface of the lung that is filled with air ("bleb") ruptures allowing air to pass into the thoracic cavity. Young men who are tall but otherwise healthy are classic presenters of primary spontaneous pneumothorax. In general the rate of PSP is 7.4/100,000 men per year in the U.S. and less for women at 1.2/100,000 per year. (27)

Secondary spontaneous pneumothorax (SPS) is defined as pneumothorax that occurs as a complication of underlying lung disease like chronic obstructive pulmonary disease (COPD), cystic fibrosis, sarcoidosis or lung cancer and so on. (28) 50 to 70% of SSP is associated with COPD in the literature case series. (29)

Traumatic pneumothorax is caused by penetrating or blunt trauma to the chest such as a stabbing, gunshot wound or severe blow. Iatrogenic pneumothorax results from a complication of a diagnostic or therapeutic intervention. (30) Pneumothorax from acupuncture is an example of iatrogenic pneumothorax.

Pneumothorax is a risk of acupuncture needling occurring only twice in nearly a quarter of a million treatments according to Ernst & White: "Those responsible for establishing competence in acupuncture should consider how to reduce these risks." (30) Yamashita et al. found 25 cases of pneumothorax in Japanese literature as of 2001. (18) Reviewing the Chinese literature, Zhang et al. found 201 cases of thoracic organ and tissue AEs with pneumothorax being the most

frequent. (31) Most recently a Xu et al. review of pneumothoraxes reported a total of 13 acupuncture-related pneumothoraxes published from 2000 to 2010 in from China, Japan, UK, New Zealand, Singapore and the U.S. (6) However, additional cases were reported in this time period (32-37) and reports of cases since the Xu et al. review (38-43) indicate pneumothorax continues to be a risk of AE in acupuncture practice.

Symptoms of acupuncture-related pneumothorax can present immediately upon penetrating the lung or hours later. Symptoms may include dyspnea (shortness of breath) on exertion, tachypnea (increased respiratory rate), chest pain, dry cough, cyanosis, and diaphoresis/sweating. (44) Acupuncture practitioners can be unaware of having created a pneumothorax or what point or points were implicated because patients, by necessity, report to an emergency department, and the information regarding practitioner or points used is not recorded.

Patients at increased risk for pneumothorax from acupuncture include cigarette smokers and marijuana smokers and those suffering from lung disease such as chronic asthma, emphysema and COPD as well as patients with lung cancer or who are on corticosteroids. (35) Patients with Marfan syndrome, homocystinuria, and thoracic endometriosis are also more predisposed to PSP than others. (30)

Patients with chronic lung disease will have loss of muscle mass; their musculature thins and “barrels” because ventilatory muscles are chronically overloaded and overworked from airflow obstruction and hyperinflation.

Pneumothoraxis is also a complication of dry needling. This can be seen with the patient who suffers a pneumothorax during a demonstration of deep dry needling (DDN) to treat the iliocostalis muscle. (45)

The primary areas associated with acupuncture or dry needling-induced pneumothorax are the regions of the thorax including the upper trapezius, thoracic paraspinal, medial scapular, and subclavicular areas. (44)

It is critical that a medical history establishes or rules out increased acupuncture-pneumothorax risk factors such as smoking, including marijuana smoking, and/or history or presence of lung disease such as chronic asthma, emphysema, COPD, lung cancer and/or taking corticosteroids. It is also critical to assess the physique of a patient. A very tall, thin patient or one with atrophy or muscle mass loss from hyperinflation will have a shallow surface to lung depth, increasing the risk of penetrating the lung resulting in pneumothorax. Needling should be limited to superficial penetration over the chest, back, shoulder and lateral thoracic region, no deeper than the subcutaneous tissue. It is also strongly recommended to use needles that are not

longer than safe needling depth at any thoracic region area including the Huatuojiagi points, bladder channel, and any intercostal space.

Safe needling depth is recommended at 10-20 mm; less than the face width of a U.S. nickel, 20-cent Euro coin, Canadian 25-cent piece or English 20 pence. Rather than needling at a perpendicular angle, it is strongly recommended to needle at an oblique angle. This also ensures that needles will not travel deeper into the body. Placing a blanket over needles in the thoracic area caused needles to be inserted deep enough to cause a pneumothorax in one reported case. (46) Oblique needle placement would prevent this complication.

Care should be taken when needling the GB 21 (Jianjing) and the upper trapezius muscle since the apex of the lung extends 2–3 cm above the clavicular line. (44) Incorrect needling of this area has been associated with pneumothorax.

Points most frequently associated with pneumothorax events in the Chinese literature (31) are: Jianjing (GB 21; 30%), Feishu (BL 13; 15%), Quepen (ST 12; 10%), and Tiantu (Ren 22; 10%); infrequent events occurred at Ganshu (BL 18), Jiuwei (Ren 15), Juque (Ren 14), Jianzhen (SI9), Quyuan (SI 13), and Dingchuan (EX-B1).

Peuker & Grönemeyer identify risk points ST 11 (Qishe) and ST 12 (Quepen), LU 2 (Yunmen), ST 13 (Qihu), KI 27 (KI 22-27), and ST 12-18. (47) However, any points needled in the thoracic body region risk penetrating the lung, including the front, back, or lateral body, the lower neck, shoulder and scapular region as well as the chest, ribs and just below the ribs depending on the position of the patient.

Safety Guidelines to Avoid Pneumothorax

Critical	<ul style="list-style-type: none"> • Obtain a medical history from a patient regarding lung function, lung diseases and smoking history before needling on the chest or back. • Assess physique of a patient. A very tall, thin patient or one with atrophy or muscle mass loss from hyperinflation will have a shorter depth of surface to lung, increasing the risk of penetrating the lung resulting in pneumothorax. • Safe needling depth to avoid pneumothorax on most patients can be as little as 10-20 mm. • Limit the depth of acupuncture needle insertion to the subcutaneous layer and initial perimysium of the intercostal muscles.
Strongly Recommended	<ul style="list-style-type: none"> • Needle at an oblique angle rather than at a perpendicular angle in the thoracic body (from the top of the shoulders to the T-10 area on the back, or from the top of the shoulders to the xiphoid level on the chest). This also ensures that needles will not travel deeper into the body from the weight of a sheet or gown used to cover the patient. • Limit vertical manipulation of needles on the chest or back.

	<ul style="list-style-type: none"> • Do not cup over needles on the thorax in the area of the lungs to avoid tissue compression that can cause needle penetration to internal organs. • If there are indications or suspicions that an organ may have been punctured, emergency transport should be called to take the patient to an emergency medical facility.
Recommended	<ul style="list-style-type: none"> • Avoid using needles that are longer than the safe needling depth for a particular body area. • One method to reduce risk at GB 21 (Jianjing): While isolating and lifting the trapezius muscle with a pincer grip using the opposite hand, needle across the muscle at GB 21 (Jianjing), taking care to direct the needle obliquely and not inferiorly toward the lung.

Injury to Other Organs

Injury to internal organs is a reported serious adverse event of acupuncture. (1,6,31) Heart injury is an extremely rare complication of acupuncture; however, fatalities have been reported. Xu et al. (6) report five cases of heart injury include two of cardiac tamponade and three other heart injuries during a 12 year period. Ernst and Zhang report 26 cases of cardiac tamponade with 14 fatalities since 1956; however cases of self-injury and accidental injury are included along with cardiac injury during acupuncture. (48) As an example, a case that is still sometimes cited as an “acupuncture fatality” resulted from a self-inflicted sewing needle and not from actual acupuncture practice. (49) Of the cases reported by Ernst and Zhang, only one is of a needle penetrating a sternal foramen, three were self-treatment when the goal of treatment was unclear. The majority of cases involved migration of needles or parts of needles broken off in the body. (48) Such embedded needles are not part of modern acupuncture. Excessive needle length (60 mm) is described as contributing to another case report and must be avoided. (50)

Although rare, the risk of sternal foramen must be considered. Insertion through a congenital defect in the sternum appears to be the mechanism of injury in two of the cases reported by Ernst and Zhang. (48,51,52) In a case reported from Austria in 2000, an emaciated 83-year-old woman was needled at Ren 17 (Shanzhong). The needle was inserted by an experienced acupuncturist through a sternal foramen. Symptoms appeared within 20 minutes. The report describes that the 30 mm needle may have been inserted perpendicularly in an emaciated patient. (52) Peuker and Grönemeyer (53) report that the incidence of a sternal foramen at the level of the fourth intercostal space exists in 5-8% of the population. This demographic is confirmed in recent CT studies. (54) Palpation cannot reveal the defect (53) and there is no correlation between the depth of subcutaneous fat and distance to a vital organ. (54) While the placement of internal organs directly under a sternal foramen and the depth from skin to organ

varied, CT scans suggest that 25 mm is the maximum safe insertion depth to avoid injury to the heart. (54)

In addition to depth, angle of insertion when needling the chest must be considered. Oblique or transverse needling on points located on the chest and avoiding an upward direction at Ren 15 (Jiuwei) is critical to prevent heart injury.

Symptoms of cardiac tamponade include anxiety, restlessness, low blood pressure and weakness, chest pain radiating to the neck, shoulder, back or abdomen, chest pain that gets worse with deep breathing or coughing, problems breathing or rapid breathing, discomfort that is relieved by sitting or leaning forward, fainting or light-headedness, palpitations, drowsiness, and/or weak or absent peripheral pulses.

There are reports in the Western literature of injury to other internal organs but most are not recent. Zhang et al. (31) review serious AEs from the Chinese literature and report 16 cases of abdominal organ and tissue injury including perforations of the gallbladder, bowels, and stomach with peritonitis. Injury was attributed to needling too deep; the points cited are ST 25 (Tian Shu), Ren 12 (Zhongwan), and LR 14 (Qi Men) in the treatment of abdominal pain, appendicitis or cholecystitis.

Reporting on an acupuncture needle that remained in a lung for 14 years, Lewek et al. reviewed 25 cases of migration of needle fragments and they include to the liver, pancreas, stomach, colon, breast, kidney, and muscles and spinal cord. (55) Additionally, there are case reports of foreign body stones formed around needle fragments in the ureter (56) and bladder. (57) As mentioned above, such embedded needles are not part of modern acupuncture.

Before administering acupuncture, special care should be taken to examine the patient for any suspected organ enlargement. Abnormal changes in the internal organs may come from a variety of diseases. Changes in heart size may be a result of chronic hypertension and congestive heart failure. Hepatomegaly may be a result of a number of diseases including alcoholism, chronic active hepatitis, hepatocellular carcinoma, infectious mononucleosis, Reye's syndrome, primary biliary cirrhosis, sarcoidosis, steatosis, or tumor metastases. Splenomegaly may be caused by infections such as infectious mononucleosis, AIDS, malaria, and anaplasmosis (formerly known as ehrlichiosis); cancers, including leukemia and both Hodgkins and non-Hodgkins lymphoma; and diseases associated with abnormal red cells such as sickle cell disease, thalassemia, and spherocytosis.

Puncturing the liver or spleen may cause internal bleeding, although severe responses are rare and no cases of liver or spleen injury have been reported in English in the past twelve years. (6) Symptoms of such organ injury include abdominal pain, rigidity of the abdominal muscles,

and/or rebound pain upon pressure. Puncturing the kidney may cause pain in the lumbar region, tenderness and pain upon percussion around the kidney region, and bloody urine.

Central Nervous System Injury

Acupuncture-related central nervous system injuries are reported more often in Eastern literature. (3,53) Xu et al. (6) report nine cases of central nervous system injury over the 12 year period reported in that document. Like the heart injury cases reported above, a few spinal cord injuries were caused by migrating broken needles. Deep needling may also cause damage to the spinal cord. According to Peuker and Grönemeyer, "The distance from the surface of the skin to the spinal cord or the roots of the spinal nerves ranges from 25 to 45 mm, depending on the constitution of the patient. Deep needling of points of the inner line of the bladder meridian (BL11 to 20) was particularly likely to cause lesions of the spinal cord or the spinal nerve roots." (53)

Safety Guidelines to Avoid Organ and Central Nervous System Injury

Critical	<ul style="list-style-type: none"> • Observe safe needling depth and angles to avoid cardiac injury. <ul style="list-style-type: none"> ○ To avoid penetration at a sternal foramen, use an oblique angle to needle on the sternum. ○ Limit the depth of acupuncture needle insertion to the subcutaneous layer. • Needling Du 22 (Xinhui) in an infant is prohibited.
Strongly Recommended	<ul style="list-style-type: none"> • All patient histories should include information about current or past diseases that might lead to a change in the size of the organs. • Do not cup over needles on the abdomen to avoid tissue compression that can cause needle penetration to internal organs. • Limit vertical manipulation of the needles on the abdomen.
Recommended	<ul style="list-style-type: none"> • If there are indications or suspicions that an organ may have been punctured, emergency transport should be called to take the patient to an emergency medical facility. • Avoid using needles that are longer than the safe needling depth for any given body area.

Traumatic Tissue Injury

Peripheral Nerves

Peripheral nerve injuries are reported infrequently (53) and may include a needle fragment within the carpal tunnel causing median neuropathy, median sensory neuropathy from needle injury, (59) peroneal nerve palsy, (60) and in one case resulting in drop foot. (61) Four cases of peripheral nerve injury are reported in China, three related to needling of LI 4 (Hegu) on the hand. Included in this report was the observation that a forceful needle manipulation at this

point can cause peripheral nerve injury. (53) A case of Bell's palsy 24 hours after acupuncture is reported by Rosted & Woolley. (62)

Blood Vessels

Two cases of vascular injury are reported in the U.S.: acute intracranial hemorrhage in a patient given acupuncture for neck pain (63) and cerebrospinal fluid fistula in a patient treated for low back pain with embedded needles. (64)

Acupuncture needle nicks to a capillary or vein resulting in minor bleeding or superficial hematoma are not uncommon. Injuries to blood vessels resulting in more serious complications, such as compartment syndrome, deep vein thrombosis, popliteal artery occlusion, aneurysm and pseudoaneurysm as well as arterial injury are rare but are reported. (4,65) More recently a serious thigh hematoma resulted from acupuncture treatment in an 82-year-old woman taking warfarin. (66) Her INR was stable at 2.4; it appears the additional risk factors in this case related to deep needling and the age of the patient complicated by anticoagulant therapy.

Safety Guidelines to Avoid Traumatic Tissue Injury

Critical	<ul style="list-style-type: none">• Follow <i>Safety Guidelines to Prevent Bruising, Bleeding and Vascular Injury</i>.
Strongly Recommended	<ul style="list-style-type: none">• To reduce risk of peripheral nerve injury; avoid aggressive needle manipulation in anatomical areas with a record of risk such as the hand and wrist, ankle and fibular head.• If a patient experiences acute severe pain from needling a point do not continue to manipulate the needle but withdraw to a shallower depth or remove it entirely.

Infections

Infections may be local or systemic, due to an autogenous source (the patient) or be a cross infection (from the practitioner or others). One in three people are carriers of *Staphylococcus aureus*, and 1 in 10 is a carrier of MRSA. Likewise, *Mycobacterium* may be part of common skin flora. A carrier may have no symptoms or indications they are a carrier unless they are tested, typically with swabs of the skin, nose or mouth. *S. aureus* or MRSA can infect wounds and prevent healing, cause blood infection (septicemia), or infect organs, bone, heart valve/lining or lung, and/or create an internal abscess. Patients are often hospitalized, may require surgery, months of IV antibiotics and may experience lifelong sequelae or even death.

Recent reports of acupuncture-related infection are of skin and soft tissue such as mycobacterium including *Mycobacterium abscessus* and *Staphylococcus aureus* including MRSA. Of the 239 cases reported for the period of 2000-2011, 193 were mycobacterium infection. The source of most of these infections was traced to reuse of improperly disinfected

needles or therapeutic equipment or use of contaminated disinfectant or gel used for related procedures. (6)

While infections associated with acupuncture needling are a rare occurrence, any disruption of the normal barriers to infection, such as puncturing through the skin and epidermal flora, can allow a pathogen to enter the body. Those with a reduction in normal immune function may then not respond adequately to the pathogen, allowing an infection to start. Reduction in normal immune function may take place due to a number of life situations and diseases such as in persons who have significant stress, use corticosteroids and other immune suppressing drugs, or who have cancer or immune suppressing diseases such as AIDS. As other conditions and diseases may also compromise immune function, acupuncture practitioners should take care to use Clean Needle Technique with all patients to prevent infections.

Care should be taken to limit even the rare but measurable risk of infection associated with needling. The Clean Needle Technique discussed in Part II of this manual is designed to limit exposure of patients from both autonomous and cross infections, and to limit exposure of practitioners and their staff from infections which are part of any medically-related practice.

See Part IV for a more thorough discussion of healthcare associated infections.

Safety Guidelines to Prevent Infection

Critical	<ul style="list-style-type: none">• Follow Clean Needle Technique.• Follow Standard Precautions: Consider all patients as if they are carriers of bloodborne pathogens such as Hepatitis (HBV), Hepatitis C (HCV), HIV, Staph or MRSA.• Follow <i>Safety Guidelines for Hand Sanitation</i>.• Follow <i>Safety Guidelines for Preparing and Maintaining a Clean Field</i>.• Follow <i>Safety Guidelines for Skin Preparation</i>.• Use only single-use sterile needles and lancets.• Check needles before use for sterilization expiration dates, breaks in the packaging or any evidence that air or water has entered the needle packaging prior to use.• Wear gloves or finger cots or otherwise cover up any areas of broken skin on the practitioner's hands.• Maintain clean procedure at all times while handling needles before insertion. If needles or tubes become contaminated, they should be discarded.• Do not needle into any skin lesion. Acupuncture needles should never be inserted through inflamed or broken skin.• Use only sterile instruments when breaking the skin surface (needles, plum blossoms, and lancets).• Immediately isolate used needles in an appropriate sharps container.
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	<ul style="list-style-type: none"> • When using a multi-needle pack of sterilized needles, once the packaging is opened for one patient visit, any unused needles must be discarded properly and not saved for another patient treatment session. • Follow guidelines for disinfecting reusable adjunct therapy tools after every use. • Use new table paper (or clean linen if using cloth coverings) on each treatment table for each new patient visit. • Wipe down each treatment chair or table with a disinfectant solution or disinfectant cloth between each patient visit.
Strongly Recommended	<ul style="list-style-type: none"> • Guide tubes must be sterile at the beginning of the treatment and must not be used for more than one patient. • When needle stabilization is needed, the practitioner should use sterile cotton or sterile gauze to stabilize the shaft of the needle. • If you stick yourself with a used or contaminated needle, seek medical advice. • Clean all treatment room surfaces with approved disinfectants daily.
Recommended	<ul style="list-style-type: none"> • While it is acceptable to palpate the cleaned area of skin to precisely locate the acupuncture point after the skin is cleaned and before needling, the practitioner should not trace fingers or hands across a wide area of skin to locate an acupuncture point after the skin is cleaned and before needling. • When desired after needle withdrawal, apply pressure to the acupuncture point with clean cotton or gauze. • Clean all office common use areas with an approved disinfectant daily.

Broken Needle

The advent of the single-use disposable sterile stainless steel acupuncture needle has significantly reduced the previously uncommon but occasionally occurring broken needle. Metals are made brittle by the heating and cooling associated with autoclave sterilization procedures; moreover, the quality of metal materials used for needles has advanced. With single-use needles, the risk of the broken needle approaches zero. However, manufacturing errors may still allow for such events and the practitioner should be aware of how to handle such a situation. Neither White (3) nor McPherson (14) reports any broken needles during their prospective studies. Witt et al. reports 2 broken needles out of 229,230 patients treated. (5)

A broken needle may occur if: (a) there are cracks or erosions on the shaft of the needle, especially at the junction with the handle; (b) the quality of the needle is poor; (c) the patient has changed position to too great an extent; (d) there is a strong spasm of the muscle; (e) excessive force is used in manipulating the needle; (f) the needle has been struck by an external

force; or (g) a bent needle has been rigidly withdrawn. In an era when only single-use disposable needles should be used, needle breakage has become a highly unlikely occurrence.

To manage a broken needle, the acupuncturist should remain calm and advise the patient not to move so as to avoid causing the broken part of the needle to draw deeper. If a part of the needle is still exposed above the skin, remove it with forceps. If it is on the same level with the skin, press the tissues around the site gently until the broken end is exposed, then take the needle out with forceps. If it is completely under the skin, seek medical help immediately. Do not cut the flesh to get access to the needle. Remove all other needles. Call for emergency transport to a hospital or medical facility where a physician can remove the needle shaft.

The most effective way to prevent a broken needle is compliance with single-use disposable needles. If needles or packaging appear defective in any way, do not use those needles for patient care. Dispose of the defective needle in a sharps container and use another sterile needle. Use the appropriate needle size and length for the location and technique to be used.

Safety Guidelines to Prevent Broken Needles

Critical	• Inspect needle for defects in manufacturing before use.
Strongly Recommended	• Use only single-use sterilized needles. • Never insert a needle to the handle.

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Clean Needle Technique Course: FAQs

Question 1: What is the Clean Needle Technique course?

A. The Clean Needle Technique (CNT) course is a one-day program that includes a lecture, a demonstration, and written and practical examinations. This course was originally developed in 1985 by the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) as part of a program of certification of professional competence to practice acupuncture safely and effectively. In 1990, the NCCAOM transferred the responsibility for administering the CNT course to the CCAOM. Over the years, the CCAOM has continued to develop and improve the rigorous, state-of-the-art CNT course, which contains both theoretical and practical components.

Question 2: What is the purpose of the CNT Course?

A. The basic rationale upon which the Council's CNT course is premised is that there is a need for a national standard in the area of clean needle safety to ensure public safety by preventing clinical accidents. The need for a national certification standard in needle safety is strongly supported not only by the national association of AOM colleges (CCAOM), but also by the national accrediting agency for the AOM profession (ACAOM). The Council's CNT course serves the interests of public safety by ensuring that graduates of AOM programs, both domestic and foreign, are informed of and have demonstrated competency in a uniform national standard of needle safety.

Question 3: Who is eligible to take the CNT course?

A. The CNT course is designed for the following categories of individuals:

(1) currently enrolled AOM students whose program of study requires them to take the CNT course; (2) AOM students or graduates who wish to receive NCCAOM certification; (3) AOM students, graduates or practitioners whose state licensing board requires completion of the CNT course. In addition, some insurance carriers or employers may require completion of a recent CNT course, and some state boards governing the practice of detoxification (NADA) specialists may require completion of the national CNT course as well.

Question 4: Why should I take the CNT course?

A. National certification in the field of acupuncture requires an applicant to have successfully completed the CCAOM CNT course. Although needling technique and safety is a required course at accredited acupuncture schools in the United States, the NCCAOM as well as most state licensing boards recognize that independent verification of CNT competency by those wishing to practice acupuncture is essential in the interest of public safety. The content of the CNT course provides a uniform standard of practice for acupuncture in the United States. This course does not, however, replace other coursework in techniques, risk management, clinical safety or the standard of the Occupational Safety and Health Act or the Centers for Disease Control and Prevention.

Question 5: Why is it important to maintain national standards in the area of CNT?

A. It is essential that competency in safe needling technique by those wishing to practice acupuncture in the United States be verified to ensure the safety and health of patients, as well as practitioners and members of the public. Confidence in the safety of acupuncture by consumers, regulators, and third party payers is also a necessity in order to foster the general acceptance of acupuncture as a treatment option in the United States.

Question 6: When and where are CNT courses offered?

A. The CCAOM offers between 50 and 60 CNT courses annually in various cities throughout the United States, and occasionally in Canada, China, and Korea. The courses are offered on weekends for the maximum convenience of applicants. Except for international locations, CNT courses are offered at CCAOM member colleges. This website contains a complete list of CNT course dates (<http://www.ccaom.org/cntschedul.asp>) as well as the application form (<http://www.ccaom.org/cntapp.asp>).

FAQ Dry Needling Adverse Events



Physiotherapy Alberta
Physiotherapist
2015-2016

Introduction

Dry needling is associated with risks that can lead to adverse events. Physiotherapists are legally obligated to ensure they obtain informed consent from their patients. The dry needling informed consent process requires material risks and special risks of treatment be disclosed to patients.¹⁴

Research into adverse events related to dry needling is continually evolving. There are wide variations in research design including differences in the classification of adverse events which, for physiotherapists, makes interpretation and comparison between studies difficult, thus adding to the complexity of the risk disclosure process.⁸

Prior to 2014, only large scale studies examining adverse events related to acupuncture were available.^{4, 5, 10, 12, 18, 19-22}

Brady et al are the first to publish a prospective study of adverse events related to trigger point/IMS dry needling.¹

To support physiotherapist's communication with patients about the risks of dry needling, questions about adverse events associated with acupuncture and trigger point needling are answered.

1. What types of adverse events are related to dry needling?

White et al used the following system to classify adverse outcomes associated with acupuncture combining several reports including a prospective study examining 31,822 treatments.^{19, 21}

- Mild (minor) - short duration, reversible, does not inconvenience the patient.
- Significant - requires medical intervention or interferes with patient's activities.
- Serious - requires hospital admission with potential persistent or significant disability or death.

Types of Acupuncture Adverse Events by Severity*		
Mild (Minor)	Significant	Serious
<ul style="list-style-type: none"> • Bruising • Bleeding • Pain during treatment • Pain following treatment • Aggravation of symptoms followed by improvement • Feeling relaxed/energized • Feeling tired/drowsy • Feeling faint • Dizzy • Nausea • Sweating 	<ul style="list-style-type: none"> • Prolonged pain at site • Extensive bruising • Profuse sweating • Severe nausea • Vomiting • Fainting • Headache • Extreme fatigue • Severe emotional reaction • Gastrointestinal disturbance • Skin irritation • Slurred speech • Forgotten needle/patient • Seizure 	<ul style="list-style-type: none"> • Pneumothorax • Puncture of other vital tissue • Systemic Infection • Broken needle
* Adapted from White 19-21, MacPherson 10 Witt 22		

Other prospective acupuncture safety studies describe similar events but may group the mild and significant events differently.^{5, 10, 12, 18, 23} Between studies there is general agreement as to what constitutes a serious adverse event.

Brady et al studied adverse events in 7,629 dry needling/trigger point treatments and found that the types of adverse events that occurred are similar to that experienced with acupuncture.¹ A limitation of this groundbreaking study is the number of treatments is relatively small compared to acupuncture studies. All adverse events were classified as mild with the most frequent being bleeding, bruising, pain during treatment and pain after treatment.

Physiotherapists who perform needling are expected to regularly scan the literature to ensure their knowledge of probability and severity of risks associated with the dry needling technique they perform is current.

2. Are all significant or serious adverse events discussed in the information above?

No. For example cases of cardiac tamponade have been reported twice in the literature but in the large-scale prospective studies did not occur.^{4, 20} Only conditions that occurred more frequently in the large studies were listed herein.

3. How frequently do adverse events occur?

The European Commission Classification System for medicinal products⁷ has been used to discuss adverse events related to dry needling.^{1, 22}

Very Common	Common	Uncommon	Rare	Very Rare
>1/10 people treated	1-10/100 people treated	1-10/1000 people treated	1-10/10,000 people treated	< 1/10000 people treated
≥10%	≥1-10%	≥0.1% - 1%	≥0.01% - 0.1%	<0.01%

The Health Quality of Council of Alberta compared dry needling adverse events across studies⁸ and found that:

- Minor adverse events occur more frequently.
- Serious adverse event are very rare (0.04/10000 treatments).
- Pneumothorax is the most common serious adverse event and is very rare (0.01/10000 treatments).

Number of adverse outcomes reported in prospective research studies				
Research Study	# of treatments	Minor Adverse Outcome	Significant Adverse Outcome	Serious Adverse Outcome
White et al 2001	31,822 treatments	2,135	43	0
MacPherson et al 2001	34,407 treatments	10,920	43	0
Melchart et al 2004	760,000 treatments (97,733 patients)	6,936		6 (includes 2 pneumothorax cases)
Witt et al 2009	2.2 million treatments (229,230 patients)	1,976	4,963	5 (includes 2 pneumothorax cases)
Brady et al 2014	7,629 treatments	1,463	0	0
Total	3,033,858 treatments			11 serious events includes 4 pneumothorax cases

Case studies describing singular events of pneumothorax following dry needling indicate that patients were seeking treatment for a wide variety of conditions such as tension headaches, asthma, chronic cough or other breathing problems pain in the shoulder, neck, or low back regions, and complex regional pain syndrome.^{4,5}

4. Are there differences in occurrence of adverse events between acupuncture and trigger point needling?

Yes.

Acupuncture Adverse Event Rates

- Acupuncture studies report varying adverse event rates ranging from 0.9% to 11.4% (0.9%¹⁰, 0.14%²³, 7%²¹, 8.6%²², 11.4%⁵).

- Acupuncture adverse event rates in 2.2 million acupuncture treatments performed by physicians.²²
 - 19,726 of 229,230 (8.6%) patients reported experiencing at least one side effect of acupuncture.
 - Adverse events requiring treatment occurred in 2.2% of patients.
 - 39.4% of events occurred during treatment.
 - 60.6% of events occurred after treatment.
- Adverse events ranked in order of frequency of occurrence were:
 - Minor bleeding and haematoma (6.1%)
 - Pain during treatment (0.21%)
 - Pain any type (2.04%)
 - Vegetative (i.e., adverse autonomic nervous system) symptoms (0.7%)
 - Inflammation (0.31)
 - Nerve irritation/injury (0.26%)
- Adverse events due to negligence such as forgotten needle, pneumothorax comprised 0.1% of all events.
- There were no acupuncture-associated deaths or permanent injuries associated with the acupuncture treatments.

Trigger Point Dry Needling Adverse Event Rates¹

- Based on 7,629 trigger point needling treatments performed by physiotherapists.
- 1,463 adverse events were reported (19.18%).
- Adverse events ranked in order of frequency of occurrence were:
 - Bleeding 7.5% (7.55/100)
 - Bruising 5% (4.65/100)
 - Pain during treatment 3% (3.01/100)
 - Pain after treatment 2% (2.19)

Key points

- Using the European Commission Classification system,^{1,7,22} adverse events are:
 - A common occurrence when performing acupuncture.
 - A very common occurrence for trigger point dry needling.
- Most adverse events are mild in nature.
- When comparing studies on adverse events associated with acupuncture and with trigger point needling there are similarities and slight differences in the side effects patients experience.
 - Bleeding, bruising and pain are the top three side effects for dry needling and are mild in nature.

- Pain during needling occurs more frequently with trigger point needling than with acupuncture.
- Pain (during and following treatment) occurs more frequently with trigger point needling than with acupuncture.
- Serious adverse events from dry needling are very rare.
- Pneumothorax is the most common serious adverse event associated with dry needling and is very rare.

5. How do I apply this information to the disclosure process?

- When informing patients about dry needling risks, you do not have to quote statistics from the research reports. Disclose the material and special risks related to your practice context meeting your patient's informational needs.
- Bear in mind, the information provided herein provides an overview of dry needling risks from published studies. It paints a broad overview of dry needling risks. Rates of adverse events will vary from practitioner to practitioner as exemplified in Brady's study¹ which identified a subgroup of physiotherapists who had higher rates of mild adverse events than the overall group. You may be missing factual information about the rates of adverse events in your practice. As such your challenge is to combine the research information with your rate of adverse events occurrence and apply this to your disclosure process.
- Analyze your practice to gain a sense of how frequently adverse events occur. Use this information to inform the disclosure process.
 - Can you adapt the classification system for European Medicinal Products to analyze the number of adverse events that occur in your practice?
 - How frequently do your patients experience mild adverse events?
 - Are the frequency of risks reported here the same for your practice?
 - Can you use your practice data in the risk disclosure process?
- When discussing risks with patients:
 - Most physiotherapists will be able to say with confidence that they have never had a patient with a serious adverse event and defer to the research that there is a very rare risk of pneumothorax.
 - Other physiotherapists may have experienced significant or serious dry needling adverse events at rates greater than reported literature and should defer to their own practice data when discussing dry needling risks.
 - The fact that one has never experienced a serious patient safety event in their practice does not predict that one will never experience one in the future.
- Remember consent is an ongoing process. In subsequent dry needling treatments it is important to repeat information about the risks of dry needling and, when appropriate, educate patients on self-management of adverse events when they occur.

References are listed in the Dry Needling Resources Reference List.

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INDICATIONS FOR USE

DN may be incorporated into a treatment plan when myofascial TrPs are present, which may lead to impairments in body structure, pain, and functional limitations. TrPs are sources of persistent peripheral nociceptive input²⁴ and their inactivation is consistent with current pain management insights.⁷⁷ DN also is indicated with restrictions in range of motion due to contracted muscle fibers or taut bands, or other soft tissue restrictions, such as fascial adhesions or scar tissue. TrPs have been identified in numerous diagnoses, such as radiculopathies,⁷⁸ joint dysfunction,⁷⁹ disk pathology,⁸⁰ tendonitis,⁸¹ craniomandibular dysfunction,^{82,83} migraines,^{84,85} tension-type headaches,^{86,87} carpal tunnel syndrome,^{88,89} computer-related disorders,^{90,91} whiplash associated disorders,⁹²⁻⁹⁴ spinal dysfunction,⁹⁵ pelvic pain and other urologic syndromes,⁹⁶⁻⁹⁹ post-herpetic neuralgia,^{100,101} complex regional pain syndrome,^{102,103} nocturnal cramps,¹⁰⁴ phantom pain,^{105,106} and other relatively uncommon diagnoses such as Barré Liéou syndrome,¹⁰⁷ or neurogenic pruritus,¹⁰⁸ among others.¹⁰⁹

PATIENT SELECTION

Safe DN practice includes the knowledge, skills, and attributes to perform the technique, which at a minimum incorporates appropriate patient selection, creation of a safe and comfortable environment, assessment of one's own capacity to provide the treatment (eg time constraints, stress, fatigue), safe handling of needles, handling and positioning of the patient, anatomical knowledge, appropriate needle technique (direction and depth), and appropriate monitoring of the patient both during and following treatment.

Regarding patient selection, DN is appropriate for nearly all patients who present with any of the indications for DN. Physical therapists (PTs) must recognize when patients present with significant needle phobia or other anxiety about being treated with needles. PTs must decide on an individual basis whether a patient with needle phobia or significant anxiety is an appropriate candidate for DN. If DN treatment is perceived as a threatening input, it is unlikely to be therapeutic.⁷⁷ In any case, to be considered for DN, patients must be able to communicate with the PT either directly or via an interpreter and they must be able to consent to the treatment.

Caution is warranted with younger patients. Based on empirical evidence, DN is not recommended for children younger than 12 years of age. When treating children, DN should only be performed with parent and child's consent. Care should be taken assuming a child understands the procedure.

PRECAUTIONS

There are certain precautions to be considered with the use of DN:

1. Patients with a needle aversion or phobia may object to the physical therapy treatment with DN. With appropriate education, however, these patients may still consider DN.
2. Patients with significant cognitive impairment may have difficulty understanding the treatment parameters and DN intervention.
3. Patients who are unable to communicate directly or via an interpreter may not be appropriate for DN treatments.
4. Patients may not be willing to be treated with DN.
5. Patients need to be able to give consent for the treatment with DN.
6. Local skin lesions must be avoided with DN.
7. Local or systemic infections are generally considered to be contraindicated.
8. Local lymphedema (note: there is no evidence that DN would cause or contribute to increased lymphedema, ie, postmastectomy, and as such is not a contraindication).
9. Severe hyperalgesia or allodynia may interfere with the application of DN, but should not be considered an absolute contraindication.
10. Some patients may be allergic to certain metals in the needle, such as nickel or chromium. This situation can easily be remedied by using silver or gold plated needles.
11. Patients with an abnormal bleeding tendency, ie, patients on anticoagulant therapy or with thrombocytopenia, must be needled with caution. DN of deep muscles, such as the lateral pterygoid or psoas major muscle, that cannot be approached with direct pressure to create hemostasis may need to be avoided to prevent excessive bleeding.
12. Patients with a compromised immune system may be more susceptible to local or systemic infections from DN, even though there is no documented increased risk of infection with DN.¹¹⁰
13. DN during the first trimester of pregnancy, during which miscarriage is fairly common, must be approached with caution, even though there is no evidence that DN has any potential abortifacient effects.¹¹¹⁻¹¹³
14. DN should not be used in the presence of vascular disease, including varicose veins.
15. Caution is warranted with DN following surgical procedures where the joint capsule has been opened. Although septic arthritis is a concern, DN can still be performed as long as the needle is not directed toward the joint or implant.

Pneumothorax complication of deep dry needling demonstration

INTRODUCTION

Pneumothorax is a well-recognised but rare adverse event related to acupuncture or deep dry needling (DDN) over the thorax.^{1 2} This report of a pneumothorax resulting from DDN is unusual for a number of reasons: both the practitioner and the subject were doctors and both have contributed to this report; the practitioner was very experienced in DDN and had not knowingly caused such an event in the previous 45 years of practice and teaching DDN; the incident was captured on video and is presented online with this report (see online supplementary video). We hope that by reporting this event and review of the video recording we can suggest ways to reduce the risk of reoccurrence of such adverse events of DDN.

REPORT OF NEEDLING DEMONSTRATION BY PRACTITIONER

The setting was a hands-on workshop teaching the technique of DDN for the treatment of myofascial pain syndromes. The workshop used the format of lecture, demonstration on a volunteer, and then practice by the group in groups of two or three individuals at an examination couch. Safety procedures were emphasised for each muscle considered. The safety precautions included identification of landmarks each time one prepared to needle the subject and an awareness of the local anatomy and of possible complications. During the introduction to the demonstrations the complication of pneumothorax was discussed. Symptoms were described and the advice to go to the emergency department for a chest X-ray was given.

The muscle to be demonstrated was the iliocostalis muscle, one of the erector spinae muscles. RR-M

volunteered to be the subject. The lecturer emphasised the danger of pneumothorax and spoke of the technique of 'blocking' the rib by placing a finger in the intercostal space on either side of it. RR-M was a lean individual, so there was no trouble identifying the rib as he lay down. A 0.3×50 mm Seirin acupuncture needle was used to demonstrate the technique of needling the iliocostalis muscle at approximately the level of the eighth rib. A taut band in the muscle was identified by palpation against the rib. The needle was prepared and held in the right hand. The muscle was again palpated, this time with the left hand. Landmarks were identified—namely, the angle of the ribs and the intercostal spaces on either side of the rib. The taut band was identified. The intercostal spaces were blocked with the index and long fingers of the left hand, the fingers lying flat in the intercostal space so that the rib was blocked for the length of the fingers. The rib between was identified and the needle tapped through the skin using the right index finger. The intercostal space-blocking left hand fingers remained in position. The needle was advanced towards the rib with the right hand. The needle continued to advance to a depth that was deeper than expected. RR-M gave an exclamation indicating that he felt pain. The needle was withdrawn back towards the skin and RR-M was asked what the pain felt like. He said that it was an aching pain. The needle was redirected within the area blocked by the fingers of the left hand. This time, when the needle was advanced, it touched the rib at about 10–15 mm depth, indicating that the needle had slid off the rib the first time. After touching the rib with the needle and needling the iliocostalis muscle against the rib, the needle was removed.

RELEVANT BACKGROUND

MEDICAL HISTORY OF SUBJECT

The subject was a 55-year-old male medical doctor of 1.86 m height

and 68 kg weight (body mass index 20). He had a history of asthma since childhood and, at the time of the event, was well controlled on daily fluticasone/salmeterol (Seretide) and salbutamol as required. There had been no hospital admissions with asthma. He had no prior spontaneous or traumatic pneumothoraces and no history of other significant acute or chronic lung disease.

DESCRIPTION OF SYMPTOMS BY THE SUBJECT

The needling was mid-morning and by mid-day I had a deep ache and stiffness in my left chest posteriorly. It was fairly diffuse, but was centred on the scapula. This continued the rest of the day and into the next day. By the morning I was also aware of a feeling of constriction on breathing, and pain on taking or trying to take a deep breath, which I felt I couldn't actually perform fully. I also developed a dry cough, the breathlessness felt like an exacerbation of asthma symptoms (albeit more lateralised to the left) and was more noticeable on walking. I was also aware of a dull ache in the shoulder tip in the region of the acromioclavicular joint. At 2 weeks the breathlessness on exertion was lessened, but not completely gone. At 6–8 weeks I was symptom-free, but still with a pre-existing dull ache in the region of the ipsilateral acromioclavicular joint.

DESCRIPTION OF SUPPLEMENTARY VIDEO

The practitioner describes the precautions related to needling over the thorax and demonstrates identification of a taut band and how the interspaces between the ribs are 'blocked' by the fingers. A 50 mm (0.3 mm diameter) Seirin acupuncture needle is initially inserted over the identified rib, towards the taut band. The needle is inserted about 20 mm, then the practitioner pauses and the needle is inserted a further 20 mm. The latter insertion is most

likely responsible for the needle penetrating the left lung. The needle is withdrawn and re-angled slightly inferolaterally to the original angulation. The subsequent insertion results in contact with the rib at a depth of about 20 mm. It should be noted that the slightly more oblique angulation of this insertion means that the perpendicular depth of soft tissue over the rib was slightly less than 20 mm.

OUTCOME

The subject presented for his afternoon clinic at a hospital in central London the following day at approximately 13.30. He appeared well but had a dry cough and described a feeling of being unable to take a deep breath and a sense of breathlessness on the left side. We organised a chest X-ray immediately, which demonstrated a 20% left-sided pneumothorax (see figure 1). He proceeded to see the patients who had already arrived for his medical acupuncture clinic before attending our local accident and emergency unit. He was advised to manage the pneumothorax conservatively and a repeat chest X-ray at 14 weeks after the incident demonstrated a fully inflated left lung.

DISCUSSION AND ANALYSIS

Pneumothorax is a recognised complication of acupuncture and DDN.¹ The largest prospective survey of adverse events of acupuncture found two cases of pneumothorax related to 2.2 million acupuncture sessions in 0.22 million patients,² but we do not know what proportion of the 2.2 million treatments surveyed involved needling over the thorax. DDN over the thorax is very likely to be associated with a higher incidence of pneumothorax.³ A variety of techniques are used to avoid puncturing the lungs and pleura when performing needling over the thorax: superficial needling (insertion a few millimetres into the first

muscle layer or subcutaneous insertion); needle insertion at a tangent to the ribcage; needling over or onto a rib (the method used in this case).⁴ The latter is arguably the most risky, but also the most reliable way of reaching a target trigger point and, indeed, the only way of performing DDN to the target muscle layer (iliocostalis lumborum pars thoracis) in this case. It seems clear from the video that the mistake was to continue insertion beyond the first 20 mm rather than rechecking the rib position or re-angling the needle.

We suggest that, when needling over the ribcage and targeting a rib, practitioners should estimate how far they are prepared to insert the needle before rechecking the rib position. This will vary with the constitution of the subject and the position on the thorax, but in some slim individuals it may be as little as 10 mm. In this case, over the mid to lower posterior thorax we estimate that the distance to the rib was just under 20 mm.

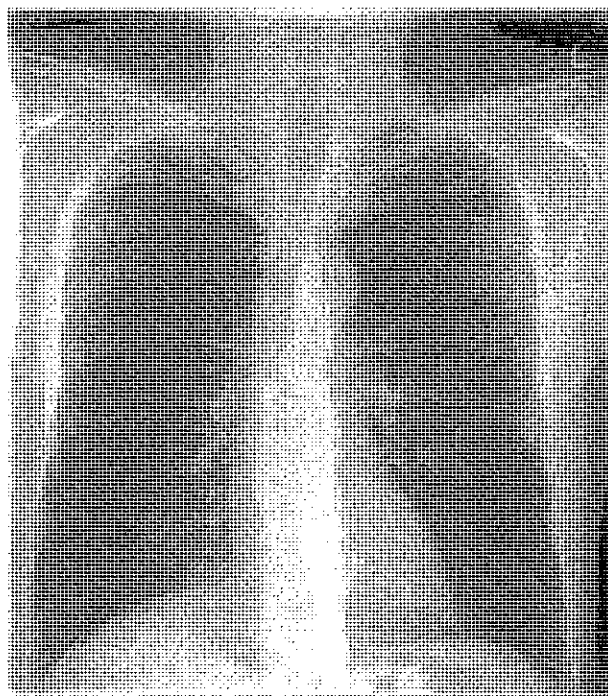


Figure 1 Chest X-ray of the patient taken approximately 24 h after the needling demonstration featured in the linked video.

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Contributors MC drafted the paper including contributions from RR-M and RG. RR-M provided a description of the adverse event from a patient perspective. RG provided a description of the demonstration from the perspective of a practitioner.

Competing interests None.

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Pneumothorax complication of deep dry needling demonstration

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CASE REPORT

An Acute Cervical Epidural Hematoma as a Complication of Dry Needling

Jun-Hwan Lee, KMD, PhD* Hyangsook Lee, KMD, PhD,† and Dae-Jean Jo, MD, PhD‡

Study Design. A retrospective case report.

Objective. The objective of this article is to report an unusual complication of dry needling.

Summary of Background Data. Epidural hematomas after dry needling are quite unusual and only a few cases of epidural hematoma after acupuncture have been reported in the literature. We are presenting the first report of acute cervical epidural hematoma after dry needling.

Methods. A 58-year-old woman presented with quadriplegia and neck pain. Magnetic resonance imaging of the spine revealed a hyperintense mass in the T2-weighted magnetic resonance image at the C2–T2 level, which proved to be an epidural hematoma.

Results. Symptoms related to the epidural hematoma resolved after decompression.

Conclusion. Though rare, epidural hematomas are a possible complication when applying needling therapies. Therapists need to have precise knowledge of human anatomy, especially in the region where he or she will puncture. Continuous attention must be paid throughout the whole procedure.

Key words: epidural, hematoma, dry needling, adverse effect.
Spine 2011;36:E891–E893

Although its mechanism of effect is unknown, the practice of inserting needles into tender points in soft tissue to alleviate pain is a common pain management procedure and is considered to be generally safe.¹ However, because the worldwide use of needling therapies, such as dry needling and acupuncture, has increased, reports of treatment complications have also been on the rise.² Complica-

tions associated with needling therapies are often transient and mild.³ Serious complications are rare, but cases of pneumothorax,^{4,5} intrathecal injection,⁶ and epidural abscess⁷ have been reported.

In this report, the authors present a case of acute cervical epidural hematoma after dry needling. To our knowledge, no cases of cervical epidural hematoma after dry needling have been reported in the literature with the exception of a few cases after acupuncture.

CASE REPORTS

A 58-year-old woman was admitted with quadriplegia and neck pain. Her medical history was unremarkable. Before treatment, she had pain in her neck and right upper extremity, and she underwent needling therapy 6 hours before admission. The needling treatment was performed as an outpatient procedure by a family physician at a private practice. Dry needling was performed at the patient's neck and arm. However, the depth of needle insertion was uncertain.

Her pain showed no improvement after treatment. However, 1 hour after treatment, sudden weakness and numbness of her right arm and leg developed. She visited an emergency room at another hospital and had T1- and T2-weighted magnetic resonance imaging scans of her cervical spine taken. An epidural high-signal intensity lesion from level C3 to level T1 with compression of the spinal cord toward the anterolateral aspect was found on those images (Figure 1). The lesion was diagnosed as an acute cervical epidural hematoma. She was advised to have appropriate decompression but for an unknown reason, she refused to undergo the operation in that hospital and was transferred to our hospital.

At the time of admission, the patient was still conscious. Nociception and temperature perception were decreased below the C3 level and were completely lost on the right side. Muscle strength was Grade I on the right side and Grade IV on the left side. She showed decreased anal sphincter tone of 50% incompetency. The patient underwent emergency decompressive laminectomy from C3 to T1 (Figure 2). At surgery, a pinpointed mark was noted over the interspinous space between C6 and C7. An organized hematoma was encountered. There was no dural tear or any clear sign of previous puncture. Mild ecchymosis was present over the paraspinal muscles adjacent to the spinous process of C7. An epidural hematoma, 9 × 1.2 × 0.5 cm in size, was noted over the right posterolateral aspect of the spinal canal, spanning from the lower part of

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Spine

4.3.2_ An Acute Cervical Epidural Hematoma as a Complication of Dry Needling.pdf

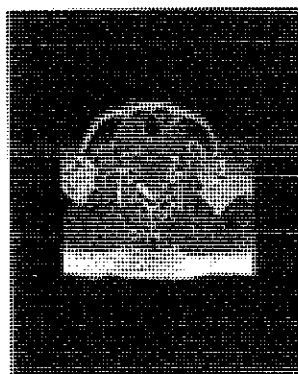
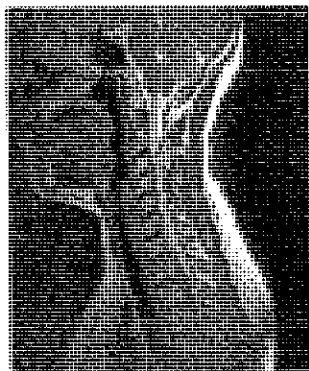
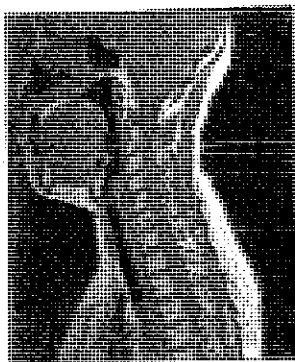


Figure 1. T1- (top) and T2-weighted (middle) magnetic resonance images from the C3 to T1 levels. Sagittal section reveals low signal intensity on T1 and high-signal intensity on T2. The spinal cord is partly compressed by the hematoma. (Bottom) T2-weighted magnetic resonance image. An axial section shows left anterolateral deviation of the spinal cord due to the hematoma.

C2 to T1. The hematoma was removed successfully and no active bleeding was noted. The thecal sac reexpanded after hematoma removal.



Figure 2. Radiograph of swimmer's view after decompressive C3-T1 laminectomy, removal of the hematoma, C3-C6 lateral mass screw fixation, as well as C7 and T1 pedicle screw fixation.

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The patient tolerated the operation well and her sensorimotor and sphincter functions improved after surgery. At 8 weeks after the operation, the patient recovered from the neurologic deficit, and her neurologic status returned to almost baseline (Figure 3).

DISCUSSION

Spinal epidural hematomas represent the most frequent acute or chronic spinal bleeding entity. Spinal epidural hematomas can be classified as idiopathic, spontaneous, or secondary, based on pathogenesis.⁸ Most spinal epidural hematomas are spontaneous, accounting for 0.3% to 0.9% of all spinal epidural space-occupying lesions, and precipitating factors include coagulopathy, neoplasm, vascular malformation, and pregnancy; however, there was no indication of any of these factors in the patient presented here.^{8,9} Another cause of spinal epidural hematoma is trauma, such as that caused by anesthetic needles, spinal manipulation, or lumbar puncture.⁹ Trauma-induced spinal epidural hematomas are uncommon⁹ and there was no history of trauma in this case other than the dry needling treatment 1 hour before the development of symptoms. The neurologic manifestations appeared soon after dry needling. Thus, the authors regarded the cervical epidural hematoma in our patient as being related to dry needling.

In general, adverse effects of needling therapies, including dry needling, and acupuncture, can be categorized into four groups: delayed or missed diagnosis (*i.e.*, orthodox diagnostic categories), adverse effects during treatment (*e.g.*, syncope, vertigo, sweating), bacterial or viral infections (*e.g.*, hepatitis B and C and human immunodeficiency virus infection), or tissue or organ trauma.¹⁰ Traumatic lesions can be further classified according to the following topographical and structural characteristics: those of the thoracic viscera (*i.e.*, pneumothorax, cardiac tamponade), abdominal viscera, peripheral nerves, central nervous

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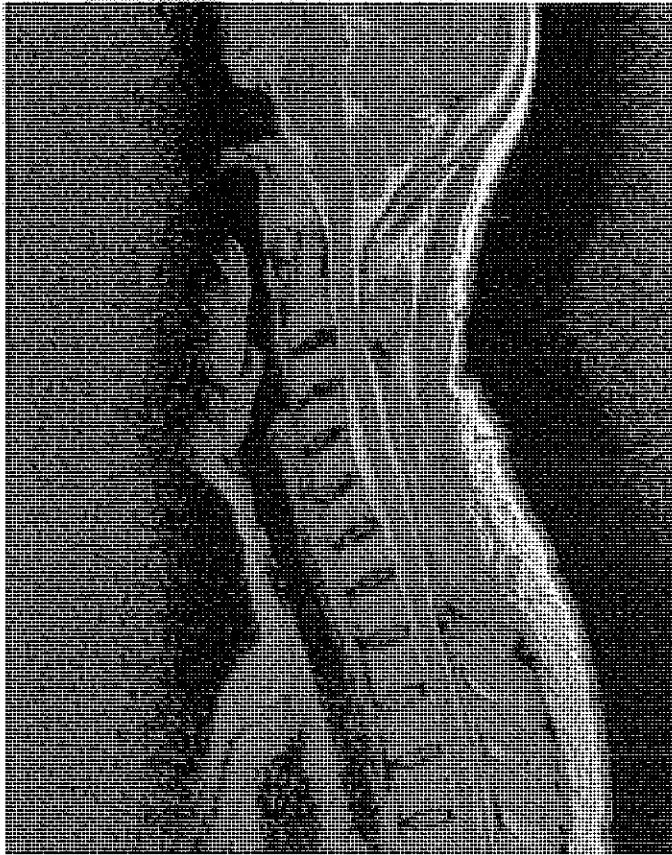


Figure 3. Postoperative sagittal T2-weighted magnetic resonance image shows no evidence of hematoma.

system (i.e., spinal cord or root of spinal nerves and medulla oblongata), or blood vessels.¹⁰ Most neurologic complications of needling are caused by spinal canal penetration, including lumbar spinal subacute epidural hematoma and meningitis,^{11,12} cervical and thoracic spinal epidural hemorrhage,^{9,13} and pneumocephalus after trapezius trigger point needling.⁶ To the authors' knowledge, the article presented here is the first to report a case of cervical epidural hematoma requiring surgical intervention after dry needling.

Although serious complications have been reported after needling therapies, they are rare. Yamashita et al³ suggest that most serious adverse effects are actually cases of negligence. The spinal epidural hematoma caused by dry needling in our patient was probably the result of unintentional needling of the spinal canal, similar to that caused by central neural blockade.⁹ Being familiar with the precise anatomy of the puncture region and paying continuous attention throughout the whole procedure is the best prevention. For example, in the cervical and upper thoracic spine region, needles should be inserted subcutaneously, caudally, and obliquely toward the spine to avoid epidural hematoma and pneumothorax. Once epidural hematoma happens, it is a serious complication, often

producing sustained neurologic deficits. Thus, prompt surgical intervention is mandatory for neurologic recovery, as was seen in this patient. However, only one previously reported case of spinal epidural hematoma after acupuncture received surgical treatment, with the other cases not receiving surgical treatment because they had only minor or no neurologic deficits.⁹

To conclude, when examining a patient with acute neurologic deficits after dry needling, nervous system injury, such as spinal epidural hematoma, should be considered, and prompt diagnosis and treatment must be attempted to avoid sustained neurologic deficits.

Key Points

- ❑ Complications associated with needling therapies are often transient and mild, and serious complications are rare.
- ❑ This report describes a case of acute cervical epidural hematoma after dry needling.
- ❑ When examining a patient with neurologic deficits after dry needling, nervous system injuries, such as spinal epidural hematoma, should be considered.

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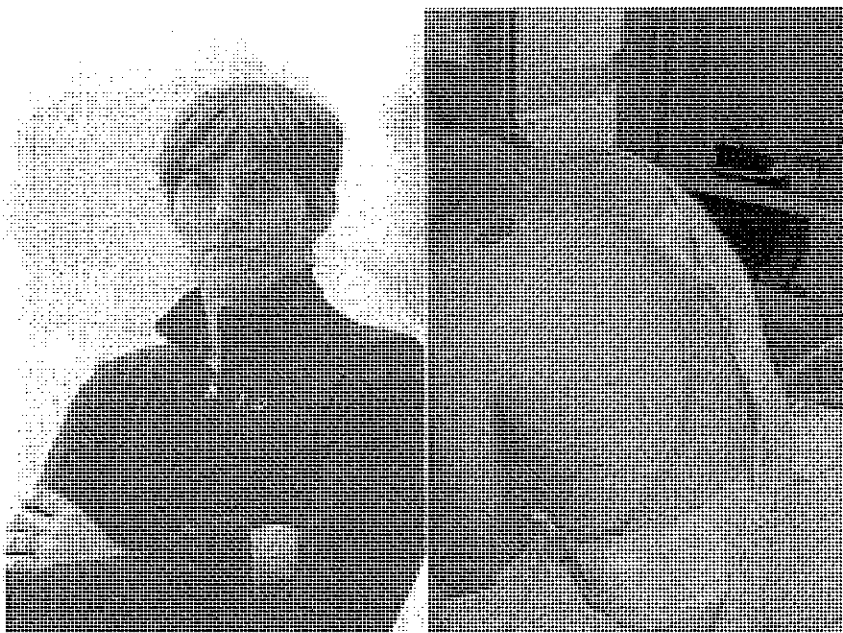
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Left: Former Olympic Champion in Judo, Kim Ribble-Orr in 2006. Right: Kim Ribble-Orr in 2013, after her lung collapsed. (Left: Glenn Lowson photo for National Post; Right: Glenn Lowson photo for National Post)

Glenn Lowson photo for National Post

Kim Ribble-Orr's 'nightmares' after acupuncture needle collapses lung

As a world-class judoka, Kim Ribble-Orr weathered an extraordinary amount of adversity — not to mention battered limbs — to achieve her dream of competing in the Olympics.

When a massage therapist tried to treat the headaches she suffered after a 2006 car crash with acupuncture, however, he set off a cascade of health problems that would shatter Ms. Ribble-Orr's sports-centred life — and raise questions about the popular needle therapy.

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The therapist accidentally pierced Ms. Ribble-Orr's left lung during acupuncture treatment that was later deemed unnecessary and ill-advised, causing the organ to collapse and leaving it permanently damaged. An Ontario court has just upheld the one-year disciplinary suspension imposed on therapist Scott Spurrell, rejecting his appeal in a case that highlights a rare but well-

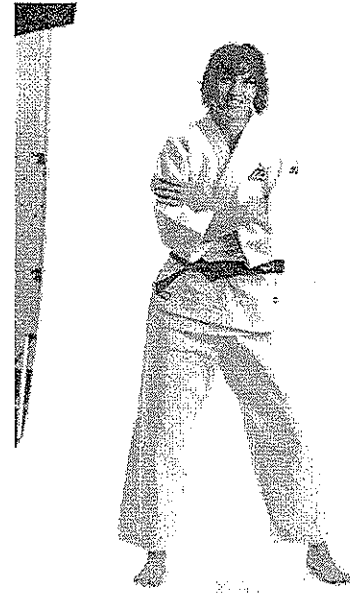
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Mr. Spurrell, who learned the ancient Chinese art on weekends at a local university, had no reason to stick the needle in his patient's chest, and had wrongly advised Ms. Ribble-Orr that the chest pain and other symptoms she reported later were likely just from a muscle spasm, a discipline tribunal ruled.

Justice Harriet Sachs of the Ontario divisional court confirmed the College of Massage Therapists' ruling in a recent judgment.

Ms. Ribble-Orr, 39, said she continues to suffer from the "nightmare" aftermath of the incident, her plans to enter mixed-martial arts or pursue a career in policing finished, activities as simple as walking up the stairs leaving her out of breath.



Kim Ribble-Orr, who competed in the 2000 Olympics in judo. She suffered in the aftermath of surgery she had after a massage therapist accidentally pierced her lung with an acupuncture needle.

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"It just ruined my life, it just changed it drastically," said the Hamilton, Ont., resident. "I had six knee surgeries [while competing in judo]. Doctors counted me out so many times, told me to quit. They were frustrated I wouldn't stop... But this thing actually beat me and it's hard to swallow."

Mr. Spurrell could not be reached and his lawyer, Amanda Smallwood, declined to comment.

The therapist had argued in his disciplinary hearing, however, that the collapsed lung might have another cause, that the acupuncture technique was appropriate, and that it would be unreasonable to expect therapists to advise patients to go to the hospital whenever they reported symptoms like Ms. Ribble-Orr's.

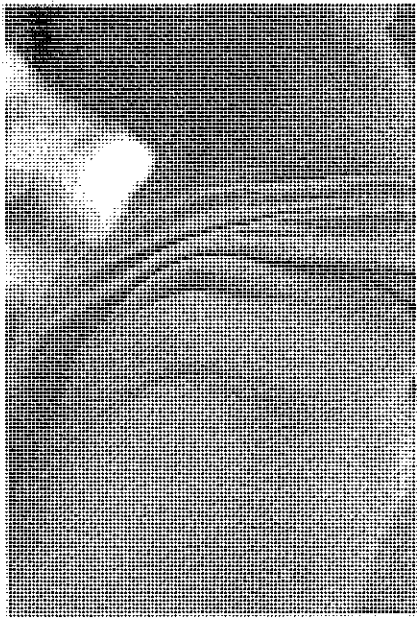
Regardless, the regulatory college had never seen a discipline complaint involving serious injury to a patient of any kind, let alone one with such devastating consequences, noted Richard Shekter, the agency's lawyer.

"It's an unusual set of facts," he said, noting that one of the country's leading lung surgeons had testified that penetrating the chest at that spot was a perilous activity.

"He said the area that this particular fellow was needling is an exceedingly high-risk area and you ne

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Kim Ribble-Orr's surgery from surgery to remove the infection caused by a punctured lung, in Burlington on July 3, 2013.

there.”

Acupuncture involves inserting solid needles into the body at specific points to encourage natural healing, improve mood and relieve pain, among other benefits, according to the Acupuncture Foundation of Canada Institute. Proponents tout it as a safe, drug-free alternative to traditional medicine, one that is used by close to one in 10 Canadians, a 2007 Alberta study suggested.

A Danish analysis of randomized clinical trials in 2009, however, concluded that acupuncture offered only a slight, clinically irrelevant benefit over placebo acupuncture for pain.

Research has also indicated that pneumothorax — a lung collapsed by air in the chest cavity — is a rare complication. A 2012 British Medical Journal study found reports of five acupuncture-linked pneumothorax cases over two years.

While the Ontario government recently set up a new college to regulate acupuncture and other types of traditional Chinese medicine, other health professions already allow their members to practice the art with some additional training, Mr. Shekter noted.

The massage therapists' college, for instance, requires that its professionals complete certain accredited courses. Mr. Spurrell did the acupuncture program at McMaster University, provided over five three-day weekends, plus 174 hours of “self-directed home study,” according to its web site.



Kim Ribble-Orr near her work in Burlington on July 3, 2013.

Glenn Lowson photo for National Post

Long before her acupuncture mishap, Ms. Ribble-Orr had extensive experience with the health-care system.

Her various injuries — both from judo and other mishaps — included a dislocated elbow and shoulder, a broken hand, head injuries and repeated knee injuries that threatened to end her career shortly before the Sydney Olympics in 2000. She also suffered a dislocated jaw in the run-up to the Games, but still managed to compete.

By mid-2006, Ms. Ribble-Orr was moving into the fast-developing sport of mixed-martial arts, while also eyeing a police job, and recovering from a car accident. She had already seen Mr. Spurrell five times when she visited him on June 21, complaining particularly of pounding headaches.

He convinced her he could curb the head pain by inserting a two-inch needle into a muscle located between the clavicle bone and ribs, the discipline ruling said.

Shortly after leaving the clinic, Ms. Ribble-Orr began having difficulty breathing, chest pain and a “grinding” sensation. S

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to the therapist later, wondering if she had suffered a pneumothorax. He told her it was more likely a muscle spasm, but said she could go to the hospital if she felt it was more serious or if the symptoms worsened.

The next morning, she did feel worse and finally headed to the emergency department. Ms. Ribble-Orr's lung had indeed collapsed and she spent the next two weeks in hospital, as a serious lung infection and then a blood infection followed. She was left with just 55% function in one lung.

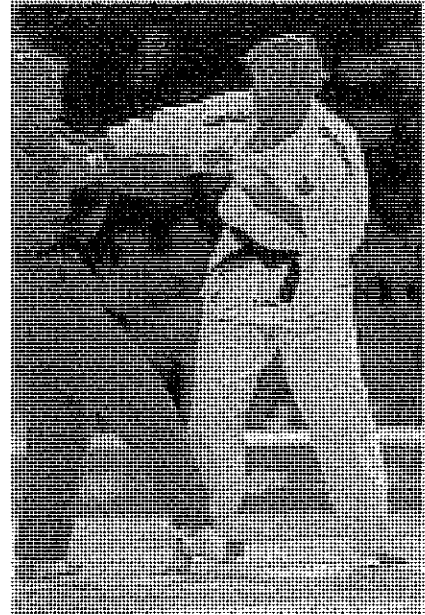
Mick Orr, her husband, said this week that he remembers how his wife had such powerful lungs before the acupuncture mishap that she could blow out a candle from across the room.

Now, she gets breathless climbing stairs, and frequently uses a puffer.

Complicating matters are hallucinations and other neurological symptoms that some doctors believe were caused or exacerbated by the post-acupuncture infections, and others say are due to the earlier car accident.

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Kim Ribble-Orr, a Canadian judoka, competes in the 73 kg weight class during a judo event at the Sydney Olympics in 2000.

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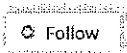


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Iatrogenic pneumothorax: safety concerns when using acupuncture or dry needling in the thoracic region

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Background: Pneumothorax is a very rare but serious complication associated with acupuncture and dry needling around the thoracic region. Physiotherapists and other health practitioners should be aware of the risks associated with needling in this region and should take care to minimize the possibility of an iatrogenic pneumothorax.

Findings: An awareness of the signs and symptoms of a pneumothorax is necessary for practitioners using acupuncture and dry needling in the thoracic region. Understanding the normal anatomy and its variants can minimize risk associated with needling practices in this region. Various technique modifications are suggested so that the pleura or lungs are avoided while using acupuncture or dry needling in the thoracic region.

Discussion/Conclusion: Acupuncture and dry needling in this region administered by well-trained physiotherapists and other health practitioners is very safe; however, to maximize safety therapists should consider the relevant anatomy and not practise using advanced acupuncture and dry needling techniques without adequate competency-based training.

Keywords: Acupuncture, Education, Iatrogenic disease, Medical error, Pneumothorax

Background

Pneumothorax is defined as air in the pleural space. For air to enter the pleural cavity one of the following events must have occurred:¹ direct communication between the alveolar spaces and the pleura; direct or indirect communication between the atmosphere and the pleural space; or gas producing organisms are evident in the pleural space. A tension pneumothorax develops when air is trapped under a positive pressure in the pleural cavity.²

The use of acupuncture and dry needling by physiotherapists and other health practitioners is increasing internationally. Systematic reviews and clinical guidelines have highlighted the benefits of acupuncture and dry needling as part of an overall management plan for patients with various musculoskeletal disorders including low back pain, pelvic girdle pain, cervical spine pain, whiplash-associated disorder, tension type headaches, and migraines.^{3–10} Pneumothorax is a very rare but serious complication associated with acupuncture and dry needling around the thoracic region.¹¹ In particular needling to upper trapezius (GB21) and to the

thoracic erector spinae and rhomboid musculature (bladder channels) have been shown to be commonly associated with iatrogenic pneumothorax. Other regions around the thorax which pose a risk of pneumothorax include the sub-clavicular region, the supra-clavicular region, intercostal spaces, interspinous spaces, and congenital foramen associated with the sternum, the suprascapular, and infrascapular fossa. Physiotherapists and other medical practitioners should be aware of the risks associated with needling around the thorax and should take care to minimize the likelihood of inadvertently creating a pneumothorax.

Classification and aetiology of pneumothorax

Pneumothoraces are classified as spontaneous or traumatic. Spontaneous pneumothorax is labelled as primary where there is no underlying lung disease present, or secondary which is associated with pre-existing lung disease. In primary spontaneous pneumothorax, 91% of cases are smokers, with the relative risk increasing with the number of cigarettes smoked, particularly in males.^{12,13} Other risk factors for primary spontaneous pneumothorax include a tall slim body type, Marfan's syndrome, pregnancy, or a family history.^{12,14} Secondary spontaneous pneumothorax may be associated with chronic obstructive

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pulmonary disease (COPD), tuberculosis, sarcoidosis, cystic fibrosis, severe asthma, idiopathic pulmonary fibrosis, malignancy, necrotising pneumonia and HIV associated *Pneumocystis carinii* pneumonia.^{1,15} Secondary spontaneous pneumothorax has also been associated with connective tissue disorders including rheumatoid arthritis (RA), ankylosing spondylitis (AS), scleroderma, systemic lupus erythematosus (SLE), polymyositis, catamenial pneumothorax and Ehlers-Danlos syndrome.¹⁻² The use of oral corticosteroids has also been associated with spontaneous pneumothorax.¹⁶

The incidence of primary spontaneous pneumothorax is 7.4-24/100 000 in men and 1.2-10/100 000 in women.^{1,13,17} Primary spontaneous pneumothorax occurs predominantly in adults in their second and third decades of life.¹² The incidence of secondary pneumothorax is 6.3/100 000 in males and 2.0/100 000 in females;¹⁷ however, in individuals with COPD the incidence increases to 26/100 000 with a 3.5-fold increase in mortality associated with secondary spontaneous pneumothorax.¹² Secondary spontaneous pneumothorax has been shown to peak in incidence in the 60- to 65-year age bracket.¹²

Traumatic pneumothorax may be iatrogenic or non-iatrogenic. Causes of non-iatrogenic pneumothorax include penetrating or non-penetrating traumatic injuries, rib fractures, and high risk professions or sports including diving or flying. The common causes of iatrogenic pneumothorax include transthoracic needle biopsy, central venous subclavian vein catheterization, thoracentesis, transbronchial lung biopsy, pleural biopsy, intercostal nerve block, suprascapular nerve block, tracheostomy, nasogastric feeding tube placement, nephrectomy, gastrostomy, cardiopulmonary resuscitation, and positive pressure ventilation.^{1,18-20} Iatrogenic pneumothorax has also been reported to occur with medical research utilizing electromyography fine wiring to assess activation of muscles including levator scapulae, trapezius, serratus anterior, rhomboids, the diaphragm, cervical and thoracic paraspinal muscles, intercostals, pectoralis major and minor, supraspinatus, infraspinatus, and subscapularis.²¹⁻²³ Similarly injections of prolotherapy solutions, botulinum toxin, anaesthetic, or cortisone into ligaments and muscles in the thoracic region have been associated with iatrogenic pneumothoraces.^{21,24,25}

Acupuncture- and Dry Needling-induced Iatrogenic Pneumothorax

Incidence

Acupuncture and dry needling has been identified as an additional cause of iatrogenic pneumothorax.²⁶ The incidence of acupuncture-induced pneumothorax is less than 1/10 000,^{27,28} which is classed as very rare by the WHO classification.²⁹ There have however been in excess of 100 case reports of iatrogenic

pneumothorax due to acupuncture and dry needling reported in the research literature, including four cases of death.^{25,27,28,30-34} Most iatrogenic pneumothoraces associated with acupuncture and dry needling are unilateral, although case studies of bilateral iatrogenic pneumothoraces have been reported.^{16,35}

Large prospective investigations into the incidence of acupuncture-induced iatrogenic pneumothorax have been conducted in the United Kingdom, Japan, Czechoslovakia, Switzerland, and Germany. During the survey of adverse events following acupuncture studies in the United Kingdom over 66 000 consultations were performed by medical practitioners and physiotherapists and there were no pneumothoraces.³⁶⁻³⁹ Similarly in Japan, no pneumothoraces occurred during a 6-year survey of 65 482 consultations conducted by acupuncture therapists.^{40,41} In Czechoslovakia, the incidence of acupuncture-induced iatrogenic pneumothorax was 2 in 139 988 equating to 1 in 69 994 consultations by hospital-based medical physicians.⁴² German acupuncture trials (GERAC) have been the largest prospective studies into the efficacy, effectiveness, and safety of acupuncture by well-trained medical practitioners to date. From the initial 763 900 consultations reviewed during GERAC, Melchart *et al.*⁴³ reported an incidence of 1/381 950 consultations; however, after 2 338 146 consultations, Witt *et al.*⁴⁴ reported the incidence of iatrogenic pneumothorax to be 1/1 170 000. The programme for evaluation of patient care with acupuncture (PEP-Ac) provided further analysis of the GERAC trials, summing that in over 4 000 000 acupuncture consultations by medical practitioners three pneumothoraces occurred equating to a risk of 1/1 300 000 consultations.^{45,46} However not all of the consultations included in the above cited prospective studies involved needling in the thoracic region. It is important to establish if a pneumothorax is spontaneous or iatrogenic because with primary spontaneous pneumothorax, the risk of recurrent pneumothorax is increased while with iatrogenic pneumothorax this risk is not increased.¹⁷

Clinical features

A good working knowledge of the clinical features of pneumothorax is vital to physiotherapists and other health practitioners practising acupuncture or dry needling in and around the thoracic region. This facilitates its early recognition and may improve the information and consent processes for these procedures. It also aids the diagnosis of spontaneous pneumothorax masquerading as a thoracic musculoskeletal condition in patients with thoracic region pain presenting for acupuncture or manual therapy.

Such presentations are well described in the physical therapy literature.^{31,47,48}

The signs and symptoms of a pneumothorax may include dyspnoea (shortness of breath) on exertion, tachypnoea (increased respiratory rate), chest pain, dry cough, cyanosis, diaphoresis (sudomotor activity), and decreased breath sounds on auscultation over the affected region.^{49,50} In rare circumstances a tension pneumothorax, which is life threatening due to displacement of mediastinal structures and resultant compromised cardiopulmonary function, may develop.⁵⁰

The symptoms of acupuncture-induced iatrogenic pneumothorax commonly do not occur until after the treatment session, sometimes taking several hours to develop. Patients need to be cautioned as to the possible symptoms of pneumothorax and what to do in the event of such symptoms. Therapists should consider if the patient has a pre-existing lung condition or any other risk factors predisposing them to spontaneous pneumothorax and thereby iatrogenic pneumothorax. Another consideration may be if the patient is going to be exposed to barometric stress, such as flying or scuba diving.

In the event of a suspected pneumothorax, either on presentation or following acupuncture or dry needling, chest percussion and auscultation may reveal hyper-resonance and decreased air entry. A plain chest X-ray should be performed if such signs are found, or indeed if any uncertainty about the diagnosis of pneumothorax remains as the diagnostic validity of percussion and auscultation in detecting pneumothorax is limited.⁵⁰ Prompt referral for medical management is indicated should a pneumothorax be found. Degrees of lung collapse have been graded as mild (<20%), moderate (20–40%), and severe (>40%).⁵¹ In otherwise healthy patients with mild iatrogenic pneumothorax monitoring as either an inpatient or an outpatient, is usually sufficient to ensure that the lung re-inflates without incident.¹⁷ Oxygen saturation levels should be considered and oxygen administered as necessary.⁴⁹ Should a larger moderate to severe pneumothorax or a tension pneumothorax develop a chest drain (pigtail catheter or tube thoracostomy) will usually be utilized over a period of days as re-expansion of the lung is achieved.

Anatomical considerations

Consideration of the relevant anatomy by adequately trained practitioners will further reduce the risk of an iatrogenic pneumothorax. The primary areas associated with acupuncture- or dry needling-induced pneumothorax are the regions of thorax including the upper trapezius, paraspinal, medial scapular, and subclavicular regions.^{16,17,26,27,31,35,48,52–56} Anatomically the lung

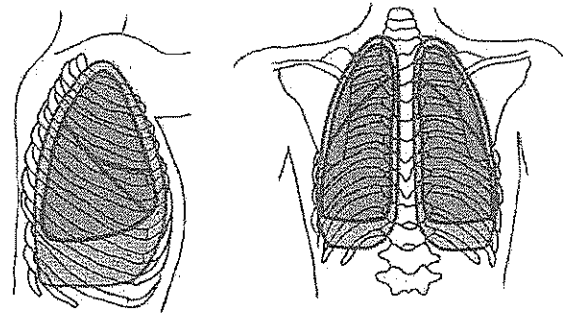


Figure 1 Right lateral view and posterior view of lungs and pleural lining relative to skeletal structures in the thoracic region.

fields extend to the sixth rib anteriorly at the mid-clavicular line, to the eighth rib laterally at the mid-axillary line and to the tenth rib posteriorly. The pleura extends a further two ribs below each of these levels (Fig. 1). This is particularly important to note posteriorly where at the lateral border of the erector spinae the pleura extends down to the twelfth rib and care should be taken when needling iliocostalis or the outer bladder channel.

The apex of the lung extends 2–3 cm above the clavicular line and care should be taken when needling upper trapezius or GB21. In individuals who smoke, additional care should be taken when needling cephalad to the first rib or in the supraclavicular region to avoid puncturing a bulla (a sharply bordered region in emphysematous lung with a diameter of less than 1 cm and a thickness of less than 1 mm) or a bleb (an air-filled cavity of the pulmonary pleura) formation which occur predominantly in the apex of the lung.^{1,48}

There are three areas in the thorax with congenital anomalies of relevance to acupuncture and dry needling regions. Congenital foraminae in the infraspinous fossa of the scapula with diameters up to 2–5 mm have been described in 0.8–5.4% of individuals.^{57,58} Such foramina have also been described in the supraspinous fossa. In 5–8% of individuals a congenital foramina exists due to incomplete ossification and fusion of the sternal plates which most commonly occur at the level of the fourth intercostals plate.^{59–61} A congenital sternal foramen is usually not able to be palpated due to overlying muscle tendon fibres and connective tissue.⁵⁹ It is, however, more likely that cardiac tamponade due to injury of the heart or pericardium could occur if needling was performed deeper than 13–25 mm directly over the sternum.⁶² Consequently physiotherapists are advised to needle superficially in an oblique cephalad direction when performing acupuncture or dry needling over the sternum.

Vulnerable areas in the thoracic region

Based on post-mortem examinations, Peuker *et al.* concluded that needle puncture depths of 10–20 mm

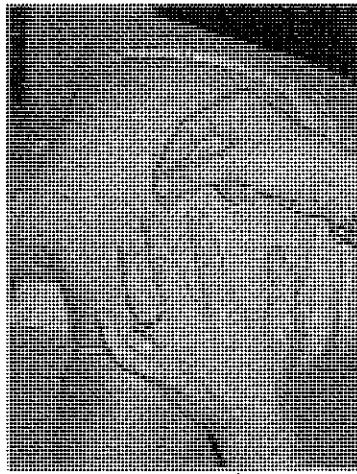


Figure 2 Needling directly over the fourth rib using an acute angle of penetration and straddling the rib with two fingers.

parasternally or in the region of the mid-clavicular line could result in a pneumothorax.^{28,48,59} Posteriorly, the surface of the lungs is 15–20 mm beneath the dermal surface in the parascapular zone.^{28,59} Case studies have been reported describing iatrogenic pneumothoraces from needling of ST11 and ST12 in the supraclavicular region and LU2, ST2, and KI27 in the infraclavicular region; KI22 and KI27 parasternally, ST12 to ST18 in the mid-clavicular line, and BL41 to BL50, rhomboids, serratus posterior superior, levator scapulae, splenius cervicis, longissimus thoracis, iliocostalis thoracis, semispinalis thoracis, cervicis and capitis in the medial scapular region.^{16,17,27,28,35,52,54,55}

When needling around the thoracic region the risks and benefits of maintaining site specificity should be considered. Numerous clinical trials and recent brain imaging studies have revealed that there is no significant difference between needling directly onto an acupuncture point compared with sham needling at a point which is a marginal distance from an actual acupuncture point.^{63,64} Hence needling points which lie directly over intercostal spaces should be avoided^{56,65} as potential benefits do not outweigh the risks. It is safer to straddle a rib with two fingers and needle directly over the rib at an acutely oblique angle (Fig. 2). Alternative safer techniques include more superficial forms of dermal needling, such as Baldry dry needling or Japanese acupuncture, using acupuncture needles of a shorter length.

Reducing the risk of iatrogenic pneumothorax

While iatrogenic pneumothorax is a very rare adverse event in association with acupuncture and dry needling³⁸ and virtually all pneumothoraces fully resolve and mortality is extremely remote, due care to prevent a pneumothorax occurring should always be observed. Additional care should be taken when dry needling or acupuncturing shoulder muscles that

have been associated with fine wire electromyography-induced iatrogenic pneumothoraces or acupuncture-induced pneumothoraces such as subscapularis, supraspinatus, infraspinatus, levator scapulae, pectoralis major and minor.^{21–23,25,65} Due to the possibility of a congenital foramen in the supraspinous or infraspinous fossa acupuncture and dry needling in this region should be directed at an oblique angle along the fossa towards the glenohumeral joint. When dry needling pectoralis major needling may be performed via a pincer grip hold in the anterior axillary region, gripping the pectoralis major between thumb and fingers, and needling performed across the fibres of the muscle. Dry needling of pectoralis minor may be performed by needling obliquely towards the coracoid process. Dry needling of the origin of levator scapulae may be performed safely if the patient's scapula is able to wing off the chest wall by lying the patient on the ipsilateral side and elevating the arm or alternatively if the patient lies on their contralateral side with their ipsilateral arm held behind their back (Fig. 3). Due to the risk of pneumothorax, it is advisable not to attempt to needle the origin of levator scapulae if the medial border of the scapulae is not able to wing off the chest wall.

Dry needling muscles on the lateral chest wall including serratus anterior and latissimus dorsi or acupuncture points in the mid-axillary line including SP17 to SP21, GB21, and GB22 also need to be considered to increase safety. Once again the technique of straddling a rib with two fingers and needling directly over the rib at an acutely oblique angle should be utilized. Latissimus dorsi can be dry needled safely by using a pincer grip hold and needling across the fibres as the muscle is lifted off the chest wall.

Needling of GB21 and particularly upper trapezius trigger points has been associated with iatrogenic pneumothorax.^{26,35,53,55} When needling upper trapezius or GB21 with the patient in a prone position, the bulk of upper trapezius is lifted in a cephalad direction using a broad pincer grip. While holding the muscle bulk the physiotherapist should attempt to lay the thumb of their non-needling hand that is holding the muscle bulk along the line of the first rib. Maintaining the position of the thumb, the upper trapezius is needled in a cephalad direction cephalad of the thumb. If a pecking style of dry needling is being utilized, the physiotherapist should ensure that the needle does not move in a caudad direction. If the acupuncture needle is being left *in situ*, its cephalad direction should be monitored to decrease the risk of upper trapezius grabbing the needle and drawing it towards the apex of the lung. Arm position should also be considered. The patient's arms may be down

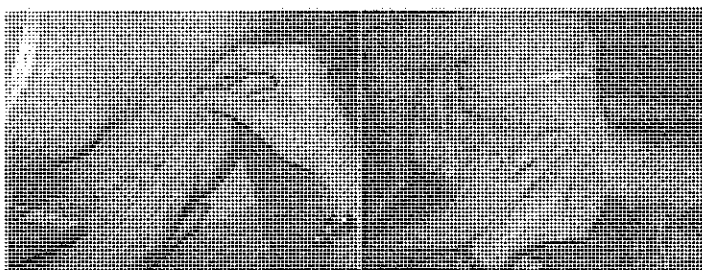


Figure 3 Needling levator scapulae by winging the scapula off the chest wall in side lying with the ipsilateral arm elevated or alternatively the patient lies on their contralateral side with their ipsilateral arm held behind their back. Note: Do not attempt to needle the origin of levator scapulae if the medial border of the scapulae is not able to wing off the chest wall.

by their side, hanging over the side of the bed or elevated onto the bed next to the patient's head. If the acupuncture needle is left *in situ*, the patient should be advised that they can only move their arms upwards towards a flexed shoulder position if they need to change the position of their arms as this assures that the needle angle will not change to point in a caudad direction (Fig. 4).

Acupuncture Training and Continuing Education

Prospective studies and retrospective surveys have determined that acupuncture and dry needling is very safe in the hands of competent practitioners who have completed adequate training programs.³⁸ It has been suggested that adequate competency-based training with regard to safety in acupuncture and dry needling minimizes foreseen adverse events.^{11,28,66} Educational levels and continuing professional development requirements are currently the subject of intense debate;⁶⁶ however, case study reviews involving needle penetration to pleura or pericardium suggest that poor practitioner judgment in terms of needle depth penetration, needling technique, and relevant anatomical knowledge is at times linked to iatrogenic pneumothorax.^{37,62} Clinical regulatory bodies should uphold professional standards and reinforce continued professional development requirements for needling vulnerable areas with such standards affecting qualified practitioners, educational bodies, and professional organizations.

Summary

The risks associated with the use of acupuncture and dry needling in the thoracic region warrant consideration in view of the growing number of physiotherapists and other health practitioners globally using these techniques. Extra care should be taken when needling patients with conditions or risk factors that have been associated with primary or secondary spontaneous pneumothorax such as COPD, lung cancer, RA, AS, SLE, sarcoidosis, Marfan's syndrome, a tall slim build, cortisone therapy, or in smokers. Any presenting signs and symptoms of a primary or secondary pneumothorax should alert the practitioner who is considering treating a patient to assess further with chest auscultation, percussion, and X-ray and referral for urgent medical management if indicated.

Iatrogenic pneumothorax relating to acupuncture or dry needling is very rare and the risk of related mortality is extremely remote. Safer techniques include needling dermally or in an acutely oblique direction over bony skeletal structures, or where possible lifting the muscle and soft tissue to be needled away from the chest wall and needling away from the underlying lung tissue. Acupuncture and dry needling administered by well-trained physiotherapists and other medical practitioners is very safe; however, to maximize safety, therapists should not perform advanced acupuncture and dry needling techniques in vulnerable areas, such as the thoracic

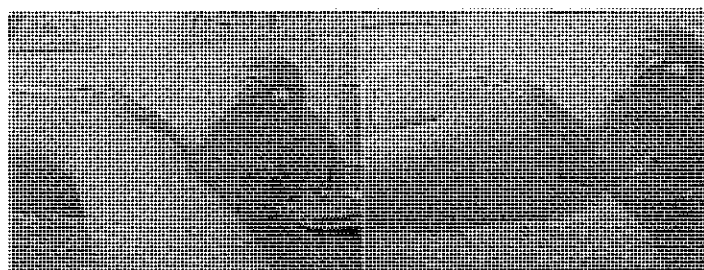


Figure 4 Angle of inclination alters with arm position when the needle is left *in situ* in upper trapezius (Gall Bladder 21). A degree of cephalad obliquity should be maintained at all times and patients should be advised that they can alter their arm position only by elevating their arms.

region, without completing adequate training by recognized educational bodies.

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March 11, 2013

American Association of
Acupuncture & Oriental Medicine

American Association of Acupuncture and Oriental Medicine (AAAOM) Position Statement on Trigger Point Dry Needling (TPDN) and Intramuscular Manual Therapy (IMT)

Summary

The American Association of Acupuncture and Oriental Medicine Blue Ribbon Panel on Inter-professional Standards has determined that dry needling and any of its alternate designations, including intramuscular manual therapy, trigger point needling, functional dry needling, intramuscular stimulation or any other method by which a needle is inserted to effect therapeutic change, is, by definition, the practice of acupuncture.

Rationale

1. Acupuncture, as a procedure, is the stimulation of anatomical locations on the body, alone and in combination, to treat disease, injury, pain, and dysfunction and to promote health and wellness.
2. Acupuncture, as a procedure, includes the invasive stimulation of said locations by the insertion of needles and the non-invasive stimulation of said locations by thermal, electrical, chemical, light, mechanical or other manual therapeutic methods.
3. Acupuncture, as a therapeutic intervention and medical practice, is the study of how the various acupuncture procedures are applied in health care.
4. Trigger point dry needling, dry needling, functional dry needling, and intramuscular manual therapy, or any other pseudonym describing acupuncture procedures, are, by definition, the practice of acupuncture.
5. In the interest of public safety, non-acupuncture boards should not regulate the practice of acupuncture.

Nationally Recognized Acupuncture Standards

The AAAOM endorses the educational standards set forth by the Accreditation Commission of Acupuncture and Oriental Medicine (ACAOM). The ACAOM is the sole agency recognized by the United States Department of Education to set educational standards for the procedure and practice of acupuncture.

The AAAOM endorses the state licensure qualifying standards set forth by the National Certification Commission of Acupuncture and Oriental Medicine (NCCAOM). The NCCAOM is the sole agency recognized by the Institute for Credentialing Excellence's (ICE) National Commission on Certifying Agencies (NCCA) to qualify acupuncturists for licensure.

State regulatory boards for licensed health care professions other than acupuncture have begun to recognize the procedure and practice of acupuncture by other names, such as “dry needling” and “trigger point dry needling.” At present, this is being done primarily by physical therapy boards in an attempt to expand the scope of practice for the physical therapy profession. Scope of practice expansion attempts made in this manner preclude necessary and adequate educational and safety standards for the procedure and practice of acupuncture. Forty-four (six pending) states plus the District of Columbia have statutorily defined acupuncture and the educational and certification standards required for acupuncture licensure. Current medical literature is consistent with the definitions of both the procedure and practice of acupuncture as provided by state practice acts.¹⁻²¹

Historical Precedents

Trigger point dry needling and intramuscular manual therapy are aliases used in the marketing of a subset of acupuncture techniques described in the field of acupuncture as “ashi point needling.”² A reasonable English translation of ashi points is “trigger points”, a term used by Dr. Janet Travell in her landmark 1983 book *Myofascial Pain Dysfunction: The Trigger Point Manual*.³ Dorsher et al.,⁴ determined that of the 255 trigger points listed by Travell and Simons, 234 (92%) had anatomic correspondence with classical, miscellaneous, or new acupuncture points listed in Deadman et al.,⁵ an internationally-recognized acupuncture reference book.

Modern authorities agree and describe dry needling as acupuncture.^{6,7,8} Mark Seem discussed dry needling in *A New American Acupuncture* in 1993.⁹ Matt Callison describes dry needling in his *Motor Points Index*¹⁰ as does Whitfield Reaves in *The Acupuncture Handbook of Sports Injuries and Pain: A Four Step Approach to Treatment*.¹¹ Yun-tao Ma, author of *Biomedical Acupuncture for Sports and Trauma Rehabilitation Dry Needling Techniques*, describes dry needling as acupuncture and provides a rich historical explanation of why.¹²

C. Chan Gunn, “Acupuncture loci: A proposal for their classification according to their relationship to known neural structures,” *American Journal of Chinese Medicine*, 1976¹³ and Peter Baldry, *Acupuncture, Trigger Points and Musculoskeletal Pain: A Scientific Approach to Acupuncture for Use by Doctors and Physiotherapists in the Diagnosis and Management of Myofascial Trigger Point Pain*, 2005,¹⁴ also acknowledge dry needling procedure and practice to be equivalent to acupuncture procedure and practice.

These examples demonstrate a Western medical movement to rename the procedure and practice of acupuncture as dry needling by providers other than acupuncturists. The examples listed above affirm that there is a literary tradition acknowledging the term “dry-needling” to be synonymous with acupuncture.

Concerns

The AAAOM has the following additional specific concerns:

- 1) No standards of education have been validly determined to assure that physical therapists (PT) using TPDN are able to provide the public with a safe and effective procedure.¹⁵
- 2) Redefining identical medical procedures and thereby circumventing or obscuring established laws regarding their safe practice is irresponsible
- 3) In many states, the addition of TPDN to physical therapy practice is being determined by physical therapy regulatory boards, deleteriously circumventing transparency and public health safety protections provided by standard legislative process

The U.S. Department of Education recognizes ACAOM as the sole accrediting agency for acupuncture training institutions as well as their Master's and Doctoral Degree programs.^{16, 17} Standards of training in acupuncture are well established, and designed to support safe and effective practice.^{18, 19} Attempts to circumvent acupuncture training standards, licensing or regulatory laws by administratively retitling acupuncture as "dry needling" or any other name is confusing to the public, misleads the public as to therapeutic intervention expected, and, through lack of meaningful education and practice regulation, creates a significant endangerment to public welfare.

This actual risk of endangerment to public welfare has been investigated by at least one malpractice insurance company that has stated it will cancel policies for physical therapists "engaging in a medical procedure for which they have no adequate education or training."²⁰ Recent actions by state medical regulatory authorities have identified and acted upon the aforementioned risk.²¹

In conclusion, the AAAOM strongly urges legislators, regulators, advisory boards, advocates of public safety, and medical professional associations to carefully consider the impact of trends in scope of practice expansion issues.

¹ <http://www.ncbi.nlm.nih.gov/pubmed/15108608>

² Janz S, Adams J. Acupuncture by another name: Dry-needling in Australia. *Australian Journal of Acupuncture and Chinese Medicine.* 2011; 6(2)

³ Travell J, Simons D. *Myofascial Pain Dysfunction: The Trigger Point Manual.* Philadelphia, PA: Lippincott Williams & Wilkins; 1983.

⁴ Dorsher PT. Trigger Points And Acupuncture Points: Anatomic And Clinical Correlations. *Medical Acupuncture.* 2006;17(3).

⁵ Deadman P, Al-Khafaji M, Baker K. A Manual of Acupuncture. Kingham, Oxfordshire Journal of Chinese Medicine Publications

⁶ When To Select Observational Studies as Evidence for Comparative Effectiveness Reviews Prepared for: The Agency for Healthcare Research and Quality (AHRQ) Training Modules for Systematic Reviews Methods Guide www.ahrq.gov Effective Health Care Program. "The AHRQ Training Modules for the Systematic Reviews Methods Guide:..." *The AHRQ Training Modules for the Systematic Reviews Methods Guide: An Introduction.* Ahrq.gov. Web. 06 Feb. 2012. <<http://www.slideshare.net/AHRQEHCPProgram/the-ahrq-training-modules-for-the-systematic-reviews-methods-guide-an-introduction>>.

⁷ Alberta Heritage Foundation for Medical Research Health Technology Assessment Unit. *Acupuncture: Evidence from systematic reviews and meta-analyses* 2002 Mar. Used in glossary of "Acupuncture for Osteoarthritis." *Centers for Medicare & Medicaid Services*. Web. 14 Jan. 2012. <<http://www.cms.gov/medicare-coverage-database/details/technology-assessments-details.aspx?TAId=19>>.

⁸ *Acupuncture for Osteoarthritis*. Rockville, MD: U.S. Dept. of Health and Human Services, Public Health Service, Agency for Healthcare Research and Quality, 2003. Print. This definition is also used in the glossary of "Acupuncture for Osteoarthritis." Centers for Medicare & Medicaid Services. "Acupuncture for Osteoarthritis." Centers for Medicare & Medicaid Services. Web. 14 Jan. 2012. <<http://www.cms.gov/medicare-coverage-database/details/technology-assessments-details.aspx?TAId=19>> 1

⁹ Seem M. *A New American Acupuncture: Acupuncture Osteopathy, the Myofascial Release of the Bodymind*. Boulder, CO: Blue Poppy Press; 1993.

¹⁰ Callison M. *Motor Point Index: An Acupuncturist's Guide to Locating and Treating Motor Points* San Diego, CA: AcuSport Seminar Series LLC; 2007.

¹¹ Reaves W, Bong C. *The Acupuncture Handbook of Sports Injuries & Pain*. Boulder, CO: Hidden Needle Press; 2009.

¹² Ma, Yun-tao. *Biomedical Acupuncture for Sports and Trauma Rehabilitation Dry Needling Techniques*. New York: Elsevier; 2010.

¹³ Gunn, C. Chan. Acupuncture loci: A proposal for their classification according to their relationship to known neural structures. *American Journal of Chinese Medicine* 4.No. 2 (1976): 183+. Print

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¹⁵ Commission on Accreditation in Physical Therapy Education (CAPTE) – Accreditation Handbook – November 2011

¹⁶ <http://ope.ed.gov/accreditation/>

¹⁷ <http://www.acaom.org/about/>

¹⁸ <http://www.acaom.org/documents/accreditation-manual.pdf>

¹⁹ <http://www.nccaom.org/applicants/eligibility-requirements>

²⁰ Letter from Allied Professional Services [on file at AAAOM]

²¹ Letter from the Oregon Medical Board [<http://www.oaaom.com/wp-content/uploads/2010/06/DryNeedling.pdf>]

AAMA Policy on Dry-Needling

Marshall H. Sager, DO, FAAMA
Rey Ximenes, MD, FAAMA

The American Academy of Medical Acupuncture (AAMA) is the premier North American organization of physician acupuncturists. The AAMA is committed to insuring public health and safety by ensuring that all persons practicing any type of medicine, including acupuncture, are properly trained and educated. It is imperative that courts and medical bodies maintain and preserve strict standards of education and training in acupuncture before any person undertakes inserting a needle into a patient. An ill-trained practitioner could, as a result of lack of education or ignorance, cause substantial medical injury.

Acupuncture, like Western Medicine is a complex subject. It cannot be mastered in a weekend or in a month. All AAMA members in addition to four (4) years of medical school (MD or DO), must have 300 hours of didactic and clinical acupuncture education and training. A non-physician must have in excess of 2,000 hours of clinical and didactic education and training before they can become certified to treat patients in most states.

Dry needling is the use of solid needles (contrasted with the use of hollow hypodermic needles that are used for injections) to treat muscle pain by stimulating and breaking muscular knots and bands. Unlike trigger point injections used for the same purpose, no anesthetics are used in dry needling. There is controversy regarding the definition of dry needling. Licensed medical physicians and licensed acupuncturists consider dry needling as Western Style Acupuncture or Trigger Point Acupuncture whereby the insertion sites are determined by tender painful areas and tight muscles. These sites may be treated alone or in combination with known acupuncture points. Other practitioners take the position that dry needling is different from acupuncture in that it is not a holistic procedure and does not use meridians or other Eastern medicine paradigms to determine the insertion sites.

Dry needling is an invasive procedure. Needle length can range up to 4 inches in order to reach the affected muscles. The patient can develop painful bruises after the procedure and adverse sequelae may include hematoma, pneumothorax, nerve injury, vascular injury and infection. Post procedure analgesic medications may be necessary (usually over the counter medications are sufficient).

There has been controversy in the United States as to who is qualified to practice dry needling. Since it is an invasive procedure using needles, many take the position that it should only be performed by licensed acupuncturists or licensed medical physicians (M.D. or D.O.). In Illinois, this sentiment was echoed by a decision to reverse legislation permitting physical therapists to perform dry needling. These and other practitioners were performing this procedure who are not trained nor do they otherwise routinely use needles in their practices.

The AAMA recognizes dry needling as an invasive procedure using acupuncture needles that has associated medical risks. Therefore, the AAMA maintains that this procedure should be performed only by practitioners with extensive training and familiarity with routine use of needles in their practice and who are duly licensed to perform these procedures, such as licensed medical physicians or licensed acupuncturists.

December 9, 2014
Adopted unanimously
Board of Directors of AAMA

CCA Position Statement on Dry-Needling

The Council of Chiropractic Acupuncture (CCA) is the main organization of chiropractic acupuncturists in the United States. The CCA is committed to insuring public health and safety by ensuring that all persons practicing any type of chiropractic acupuncture are properly trained and educated. To that end, the CCA offers post-graduate training in chiropractic acupuncture through various educational institutions. The American Board of Chiropractic Acupuncture (ABCA), which is the credentialing arm of the CCA, assures that these programs meet the stringent criteria of the CCA. The ABCA also provides board certification and testing.

To be granted board certification by the ABCA, a chiropractic physician must be a graduate of a chiropractic institution, and must have 300 additional hours of didactic and clinical education in acupuncture. This training must include clinical training and education in clean needle techniques and patient safety. Upon completion of their training the chiropractic acupuncturist must pass a rigorous examination, which includes both a written and a practical examination. There is much controversy in the United States regarding the definition of dry needling, and who is qualified to perform this procedure. Dry needling involves the use of solid needles to treat muscle pain by stimulating and breaking muscular knots and bands. Unlike traditional trigger point injections, dry needling does not use any type of anesthetic.

While both Acupuncture and Dry Needling (DN) are practiced successfully throughout the world, various types of practitioners define dry needling differently. This has led to a lot of unfortunate static that obscures the nature of what this type of needling has to offer.

On one hand, the acupuncture profession can claim, with considerable support, to have been practicing this style of treatment for at least two thousand years. Every style of needling put forward by "dry needlers" is part of some form of traditional acupuncture practice. This includes superficial needling, deep trigger point needling, short insertion, lengthy insertion, electrostimulation.

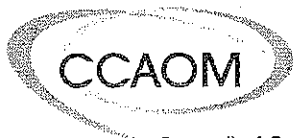
On the other hand, medical, osteopathic and chiropractic physicians may consider dry needling as Western Style Acupuncture or Trigger Point Acupuncture. Other practitioners, who are not acupuncturists but who are well placed to use this therapy to good effect, can lay claim to extensive research based material that supports an approach that seems, on the surface at least, to have little to do with traditional acupuncture practice.

Dry needling is an invasive procedure. Since needle lengths can range up to 5 inches in order to reach the affected muscles, the patient can experience adverse sequelae following treatment. This may include bruising, hematoma, pneumothorax, nerve injury, vascular injury and infection. The ABCA recognizes that dry needling is an invasive procedure using acupuncture needles that carry associated medical risks. The ABCA is of the opinion this procedure should only be performed by practitioners with extensive training and familiarity with routine use of needles in their practice. Chiropractic physicians with additional post-graduate training in acupuncture are well qualified to perform dry needling techniques.

March 1, 2015

Adopted unanimously

Board of Directors of the ABCA



Council of Colleges of
Acupuncture and Oriental Medicine

Council of Colleges of Acupuncture and Oriental Medicine*

Position Paper on Dry Needling

It is the position of the Council of Colleges of Acupuncture and Oriental Medicine (CCAOM) that dry needling is an acupuncture technique.

Rationale

A recent trend in the expansion in the scopes of practice of western trained health professionals to include “dry needling” has resulted in redefining acupuncture and re-framing acupuncture techniques in western biomedical language. Advancement and integration of medical technique across professions is a recognized progression. However, the aspirations of one profession should not be used to redefine another established profession.

In addition proponents of “dry needling” by non-acupuncture professionals are attempting to expand trigger point dry needling to any systemic treatment using acupuncture needles and whole body treatment that includes dry needling by using western anatomical nomenclature to describe these techniques. It is the position of the CCAOM that these treatment techniques are the *de facto* practice of acupuncture, not just the adoption of a technique of treatment.

Terminology

The invasive procedure of dry needling has been used synonymously with the following terms:

Trigger Point Dry Needling
Manual Trigger Point Therapy, when using dry needling
Intramuscular Dry Needling
Intramuscular Manual Therapy, when using dry needling
Intramuscular Stimulation, when using dry needling

History

The system of medicine derived from China has a centuries-long continuous distinct practice with an extensive literature over 2000 years old. After President Nixon’s visit to China in the early 1970s, public interest in and demand for

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acupuncture resulted in the establishment of first-professional degrees in acupuncture in the United States. Today over 50 accredited¹ first-professional colleges teach a diversity of styles of health care utilizing acupuncture, Chinese herbology, manual techniques such as tuina (Chinese therapeutic massage), nutrition, and exercise/breathing therapy. Individuals who attain this degree undergo a rigorous training program at a minimum standard of three academic years that contains 450 hours in biomedical science (biology, anatomy, physiology, western pathology, and pharmacology), 90 hours in patient counseling and practice management, and 1365 hours in acupuncture. Of the 1365 hours in acupuncture, 660 hours must be clinical hours.

Acupuncture is a system of medicine that utilizes needles to achieve therapeutic effect. The language used to describe and understand this effect is not limited and is articulated in both traditional and modern scientific terms. The National Institutes of Health has recognized the efficacy of acupuncture in its consensus statement of 1997² and continued funding of research. It is clear that other professions such as physical therapy and others also recognize the efficacy of acupuncture and its various representations such as dry needling due to the fact that they are attempting to use acupuncture and rename it as a physical therapy technique.

Dry needling is an acupuncture technique

As a system of treatment for pain, acupuncture relies on a category of points derived from the Chinese language as “*ashi*” (阿是) points. “*Ashi*” point theory describes the same physiological phenomenon identified as “trigger points,” a phrase coined by Dr Janet Travell³ and dates to the Tang Dynasty (618-907). While Dr. Travell coined the phrase “trigger point”, the physiological phenomenon has been long known to acupuncturists. Dr. Travell herself had contact with acupuncturists and chiropractors interested in acupuncture in the Los Angeles area in the 1980s. Dr. Mark Seem, author of *A New American Acupuncture*⁴, discussed the similarity of their techniques in the 1990s.⁵

Modern contributors from the field of acupuncture in the specialization of dry needling techniques are:

Dr. Mark Seem, Ph. D., L. Ac., published the textbook *A New American Acupuncture* covering the topic of dry needling in 1993. His books have been published for over two decades.

Matt Callison, L. Ac., is the founder of the Sports Medicine Acupuncture® certification program and the author of *Motor Points Index*. The continuing education certification program is available to licensed acupuncturists through a private seminar company and through postgraduate studies at the New England School of Acupuncture.

Whitfield Reaves, L. Ac. is the author of *The Acupuncture Handbook of Sports Injuries and Pain: A Four Step Approach to Treatment*. He also offers a

postgraduate continuing education program in Sports Acupuncture only for licensed acupuncturists.

From the above sources it is apparent that acupuncture has an established history of using treatment utilizing what are now labeled trigger points.

Documented practice of “dry needling” by acupuncturists

The National Commission for the Certification of Acupuncture and Oriental Medicine (NCCAOM), the certifying board for acupuncture, completed a job task analysis in 2003 and again in 2008. The analysis documented the prevalence of actual use of dry needling techniques, i.e. the treatment of trigger points or motor points with acupuncture needles, by practicing acupuncturists. In 2003, 82% of acupuncturists surveyed used needling of trigger points in patients that presented with pain. Of the patients that present for acupuncture treatment, it is estimated that 56% present with trigger point pain. The others present for non-pain conditions such as non-trigger point pain, digestive disorders, infertility and many other conditions. The other 18% of acupuncturists used acupuncture needling techniques in non-trigger point locations. These findings document that acupuncturists are well trained to use and have consistent historical usage of trigger and motor point “dry needling” treatment. Dry needling represents a substantial daily practice among American acupuncturists.

History of “dry needling” in North America

Dr. Chan Gunn, M.D., is the founder of dry needling in Canada. He wrote in 1976, “As a first step toward acceptance of acupuncture by the medical profession, it is suggested that a new system of acupuncture locus nomenclature be introduced, relating them to known neural structures.”⁶ One may reasonably infer from this statement that Dr. Gunn believed that in order for acupuncture to be accepted in Western medicine, the technique would need to be redefined. Using a different name for the same technique does not rise to the level of creating a new technique. Dr. Chan Gunn’s dry needling seminars are only four days in length.

Jan Dommerholt has published extensively on the technique and teaches dry needling to both western trained health professionals and licensed acupuncturists, but his teaching has been focused on the profession of Physical Therapy (PT). He argues that dry needling is a new emerging western technique described in western scientific terms. He is also attempting to redefine acupuncture based solely on eastern esoteric concepts.

A current author and provider of dry needling courses, Yun-tao Ma, Ph.D., extends dry needling beyond trigger points to include acupuncture points. He describes the points according to the neuroanatomical location and effects and calls them “Acu reflex” points. It is this adaptation and renaming of acupuncture to provide total body treatment that poses the greatest risk to the public, as it circumvents established standards for identical practice, i.e., acupuncture, without the rigorous training of acupuncture and the licensing of such.

It is the position of the CCAOM that any intervention utilizing dry needling is the practice of acupuncture, regardless of the language utilized in describing the technique.

State Board of Medicine complaints against acupuncturists for dry needling

In 2009, a physical therapist submitted a complaint to the Maryland Board of Acupuncture concerning the use of the term dry needling in chart notes by an acupuncturist. The Maryland Board of Acupuncture correctly dismissed the complaint because the procedure was done by a licensed acupuncturist trained in the use of dry needling, *i.e.*, acupuncture.

In filing the complaint, the physical therapist was not asserting that the acupuncturist caused any harm or potential of harm to the patient. Rather, the physical therapist asserted that the acupuncturist used proprietary language that was unique to physical therapy, when in fact the acupuncturist was using language that was common across professions. The Little Hoover Commission, in its 2004 report to the California legislature concluded, "interactions with other health care providers, including collaboration and referrals, as well as with many members of the public, benefit from the use of common, Western-based diagnostic terminology"⁷

Summary Position of the CCAOM on Dry Needling

It is the position of the Council of Colleges of Acupuncture and Oriental Medicine (CCAOM) that dry needling is an acupuncture technique.

It is the position of the CCAOM that any intervention utilizing dry needling is the practice of acupuncture, regardless of the language utilized in describing the technique.

Adopted November 2010
Updated May 2011

¹ The Accreditation Commission for Acupuncture and Oriental Medicine (ACAOM) is recognized by the U.S. Department of Education to accredit colleges of acupuncture and Oriental medicine and authorizes such colleges to confer Master's level first-professional degrees.

² <http://consensus.nih.gov/1997/1997Acupuncture107html.htm>.

³ Travel, Janet G., and David G. Simons. Myofascial pain dysfunction: the trigger point manual. Lippincott Williams & Wilkins, 1983, Print.

⁴ Seem, Mark. A new American acupuncture: acupuncture osteopathy, the myofascial release of the bodymind. Blue Poppy Press, 1993. Print.

⁵ Private communication of October, 2007 with Whitfield Reaves, L. Ac., who attended study groups with Dr. Travell in the 1980s, and in a letter from Dr. Mark Seem to Jan Dommerholt November 11, 2007. Seem relates his invitation and demonstration of acupuncture "dry needling" techniques to Dr. Travell in New York City in the 1990s.

⁶ Gunn, CC, Ditchburn FG, King MH, Renwick GJ, *Acupuncture loci: a proposal for their classification according to their relationship to known neural structures*, Am J Chin Med, 1976 Summer; 4(2): 183-95.

⁷ Milton Marks "Little Hoover" commission on California State Government Organization and Economy by the UCSF Center for the Health Professions, *Acupuncture in California: Study of Scope of Practice*, May 2004, pg. 13.

Conference Call Meeting Minutes
IOWA BOARD OF Physical & Occupational Therapy
December 21, 2012
Lucas State Office Building, 5th Floor Conference Room # 526
Des Moines, Iowa
Hearing was continued

Call to Order:

The meeting was called to order by Denise Behrends, Chair at 9:00am.

Roll Call:

Members Present:

Denise Behrends, OT (In the office); Morris Blankenspoor, Public Member; Bradley Earp, PT; Jackie Fleming, Public Member; Jennifer Furness, OT; Erin Hytrek, PT; and Todd Bradley, PT (joined at 9:20am)

Staff Present:

Judy Manning, Board Executive; Barb Christiansen, Administrative Assistant; Barb Huey, Bureau Chief; and September Lau, AAG

Review Agenda:

Approval of Minutes:

Motion to approve the minutes of September 19, 2012 meeting, Motion made by Fleming, second by Blankenspoor. Motion carried.

Reports:

Judy – Denise, Todd and Erin should be receiving information from the Governor's Office regarding serving another term on the Board. Denise has already served two 3-year terms and Todd and Erin have both served one 3-year term. All are eligible to serve another 3-year term. New terms begin on May 1st. The Hawkeye Community College Physical Therapy Assistant Program received CAPTE accreditation in November. Twenty-four applicants took the National Physical Therapy Assistant Exam on October 30th; 12 passed and 12 failed. Only 25% of the PTA applicants passed the exam on their first attempt which is alarming. Judy provided information on the pass/fail rate for each Iowa PTA program. Of the 12 applicants that passed the exam, 6 passed on the first attempt, 5 on the second attempt and 1 on the fourth attempt. Of the 12 applicants that failed the exam; 1 failed on the first attempt, 9 failed on the second attempt, and 2 failed on the third attempt. Beginning 1/1/2013 the licensure wall certificate will

no longer have the embossed gold seal. The new certificates will be on watermark security paper with the seal printed on the certificate.

Barb Huey: Will provide a report on board expenditures for all 19 licensure boards at the next face to face meeting. An analysis has been completed to determine if it would be feasible to merge several licensure boards with similar professions such as the Athletic Training Board with the Physical & Occupational Therapy Board. This information will be presented at the March meeting.

New Business:

Christopher Garcia: CEU issue regarding advanced level of clinical residency program for students. Discussion followed regarding allowing CEU hours for this activity. Denise suggested that a small committee should be formed to define very specific rules regarding this issue. National associations should be used as a resource for definitions as well as other states that already use this for CEU credit. Board agrees to research this issue further.

Marvin Firch sent a letter to the Board indicating that Mark Peters, PTA, was offered a contract with IPRC pursuant to a Settlement Agreement he entered into with the PT/OT Board. Mr. Peters has not completed the contract at this time so he is being referred back to the Board. As part of the settlement agreement he cannot work until he complies with IPRC so the Board will not take any action at this time.

Kevin Rippey: Oxygen adjustment by PT/OT issue during exercise. Oxygen is considered a medication. Must have a script for changing oxygen levels. Some Physicians do offer a small window of leeway (from 2 to 4 liters) should be sufficient. Board does agree that a doctor should be contacted or in the hospital setting a nurse can be contacted immediately. Board members suggested conservative action on this issue. PT's and OT's need to work within the parameters of the physician's prescription.

Brian Gauer: Signed a settlement agreement in August 2012, but has not been compliant with the agreement. Has sent e-mails to Judy Manning regarding his dissatisfaction with his treatment of the settlement agreement. September has had several conversations with him. Licensee is now discussing surrendering his license. September has now sent two letters to him regarding the surrender of his license. Board would like for the licensee to be put on inactive status to ensure he cannot practice in Iowa. Motion: Today the Board would approve modification to the stipulation with changes and give Judy permission to sign off on the modified version. Flemming/Brad.

Closed Session: Behrends made a motion to go into closed session at 9:39 am in accordance with IC Chapter 21.5(1)"d" to address discipline. Hytrek seconded. Roll call vote was taken:

Behrends, aye; Hytrek, aye; Furness, aye; Bradley, aye; Earp, aye; Fleming, aye; and Blankenspoor, aye.

A motion was made by Earp and seconded by Hytrek to return to open session at 9:59am.

Follow-up of closed session:

Case #12-017 motion to close. Denise/Todd

Case #12-005 motion to approve the settlement agreement. Jen/Morris

Case #12-010 motion to close. Brad/Todd

Case #12-011 motion to close. Denise/Erin

Case #12-012 motion to close. Jen/Brad

Case #12-013 motion to approve combined Statement of Charges, Settlement Agreement and Final Order. Denise/Todd

Case #10-010 motion to approve the Stipulated Order Suspending Probation after suggested modification has been made. Jen/Jackie

Reports:

September: Gave board members a review of the disciplinary process as it relates to hearings.

Motion to adjourn this meeting at 10:07am Jen/Morris

Meeting Minutes
BOARD OF OCCUPATIONAL THERAPY & PHYSICAL THERAPY
September 28, 2012
Lucas State Office Building, 5th Floor Conference Room #526
Des Moines, Iowa

Call to Order:

The Meeting was called to order at 9:05am by Denise Behrends, Chair.

Roll Call:

Members Present:

Denise Behrends, OT; Morris Blankespoor, Public Member; Jaclyn Fleming, Public Member; Jenifer Furness, OT; Todd Bradley, PT; Bradley Earp, PT

Members Absent:

Erin Hytrek, PT

Staff Present:

Judy Manning, Board Executive; September Lau, AAG; Barb Huey, Bureau Chief; Barb Christiansen, Administrative Assistant

Review Agenda:

Approval of Minutes:

A motion was made by Bradley to approve the meeting minutes of June 15, 2012 meeting. A second was received from Earp. All ayes, opposed none, motion carried.

A motion was made by Earp to approve the meeting minutes of July 5, 2012 meeting. A second was received from Bradley. All ayes, opposed none, motion carried.

Public Comment:

Judy, Denise and Jenifer received questions from the Occupational Therapy Association. Members will address the questions at this time. Questions are regarding administrative rules that were just adopted. Board members reviewed and discussed the questions.

Reports:

Board Executive - Judy received an email telling members that the FSBPT 2013 fee increase for exams has been deferred until 2014. Judy reported on the Executive Order 80 from the Governor's Office. This order requires departments to involve stakeholder groups when noticing

administrative rules. September clarified the orders interpretation for members by stating that Department Director's such as Dr. Miller-Meeks will determine if a stakeholder group would need to be formed. Judy stated that currently when rules changes are recommended by the Board there is a list of stakeholders that get a copy of the changes before they are noticed requesting comment. Judy and Denise attended the annual meeting held in Indianapolis, IN. Judy reported that Ohio is allowing a faxed copy of license verification form from other states. In Texas an applicant can go on line and see what stage their application is in. Texas also is considering not issuing disciplinary action against a licensee with a 1st time DUI. Texas also will accept the FCCPT evaluation of a foreign-trained applicants credentials from another state. Oregon will accept NPTE scores from another state. Montana allows licensees to print their own renewal cards. Oregon is also looking at a new software system and no longer requires a letter of reference for licensure. South Carolina is paperless for board meetings and legislation was passed to simplify the licensure process for military personnel. Uniform application for physical therapy state licensure was discussed and talked about benefits for the board and applicants. Use and abuse of social media presentation – talked about tweeting, stressed that you need a business account for patient security that is separate from your personal account. Group discussed the use of health professional minimum data set. Iowa currently collects a small amount of data from licensees during the renewal process. Kentucky Impaired Practitioner Program provided information on the function of their program for licensees.

Bureau Chief – Barb Huey reported that a check list of required documentation will be included in the Amanda Software System which will also have the ability to send e-mails to individuals informing them what is still needed for licensure. Barb reported on secure e-mail process in the department.

Chair – Denise Behrends highlighted some of the conference items including the discussion on disciplinary matters becoming more prevalent. Talked about the high percent (80%) of US educated individuals who pass the exam compared to the struggle some foreign trained individuals have to pass the exam. Lots of knowledge about the profession can be found on the FSBPT web site. FSBPT will be developing a minimum data set for PT/PTA regarding work force distribution. Dry needling is a hot topic causing 5 schools to add this to their curriculum. There has been a Task Force brought together to begin work on Tele-Health, three states have passed legislation regarding Tele-Health. There is a lot of interest in making the PTA course a four year degree. There are 280 PTA accredited programs and 80% are offered at the community college level.

AAG: September Lau – No report.

New Business:

Katarzyna Luce, Petition for Waiver - foreign trained PT, trained in Poland. Took the TOEFL exam and fell short in the speaking portion of the exam. Needed a 26 but received a 24 in speaking section of exam. Ms. Luce provided the results of the Test of Spoken English exam that she took and passed.

A Motion made by Furness to approve the Petition of Waiver regarding exam scores of Ms. Luce. A second was received from Fleming. All ayes, opposed none, motion carried.

Jean Mountain –Petition of Waiver. Rules state that if an individual is on inactive status for 5 years or less an OT needs to provide proof of completion of 30 hours of continuing education. September suggested granting a conditional license until she can complete the continuing education hours required. Ms. Mountain will have to complete the 30 hours continuing education by her next renewal. Denise suggested the board grant a conditional waiver and require Ms. Mountain to obtain 12 continuing education hours within the next 6 months. In addition Ms. Mountain will need to complete 30 continuing education hours by her next renewal.

A motion was made by Fleming to grant Ms. Mountain her license with the condition that she complete 12 continuing education hours by March 15, 2013. Ms. Mountain will have to complete the 30 hours before the next renewal period. A second was received from Blakenspoor. All ayes, opposed none, motion carried.

Nicole Essman Ronek, PT Exam - Asking permission to take exam, this will be her 4th attempt. Ms. Ronek reported she has studied with a professor to aid in her success. Ms. Ronek also has taken the PEAT exam but has not received results. Individual could take the PT exam in January 2013.

A motion was made by Furness to approve the applicant to take the PT exam a 4th time in January 2013 after providing the results of the PEAT exam to the board. A second was received from Bradley. All ayes, opposed none, motion carried.

Complaints:

A motion was made by Bradley to enter into closed session at 11:21am to discuss confidential material related to applications and complaints according to Iowa Code Chapter 21.5(1) a and d. A second was received from Fleming. Roll call taken: Behrends – aye; Furness – aye; Earp – aye; Bradley – aye; Blankespoor – aye; Fleming – aye. Motion carried

A motion was made and seconded to return to open session at 11:45am. Motion carried.

Follow-up from closed session:

A motion was made by Fleming to close case #12-009. A second was received from Earp. All ayes, opposed none, motion carried.

A motion was made by Earp to close case #10-007. A second was received from Furness. All ayes, opposed none, motion carried.

A motion was made by Blankespoor to accept the uncontested motion to dismiss Case #11-012. A second was received from Furness. All ayes, opposed none, motion carried.

A motion was made by Bradley to accept the uncontested motion to dismiss Case #12-001. A second was received from Earp. All ayes, opposed none, motion carried.

A motion was made by Blankespoor to accept the Settlement Agreement as drafted on Case #09-011. A second was received from Fleming. All ayes, opposed none, motion carried.

A motion was made by Bradley to accept the Statement of Charges as drafted on Case #12-005. A second was received from Furness. All ayes, opposed none, motion carried.

A motion was made by Earp to accept Statement of Charges as drafted on Case #12-006. A second was received from Bradley. All ayes, opposed none, motion carried.

A motion was made by Blankespoor to close Case #12-007. A second was received from Bradley. All ayes, opposed none, motion carried.

A motion was made by Furness to close Case #12-008. A second was received from Earp. All ayes, opposed none, motion carried.

A motion was made by Earp to adjourn the meeting at 11:50am. A second was received from Bradley. All ayes, opposed none, motion carried.

BOARD OF PHYSICAL & OCCUPATIONAL THERAPY
MEETING MINUTES
July 5, 2012

A meeting of the Iowa Board of Physical and Occupational Therapy was held on July 5, 2012 in Room 526, Lucas State Office Building, Des Moines, Iowa. The meeting was held in accordance with section 21.8 of the Code of Iowa entitled "Electronic Meetings". The Code states that a government body may conduct a meeting by electronic means only if circumstances are such that a meeting in person is impossible or impractical, and if the governmental body complies with the provisions of section 21.8.

CALL TO ORDER

The meeting of the Iowa Board of Physical and Occupational Therapy was called to order by Denise Behrends at 7:02 a.m.

BOARD MEMBERS PRESENT: Denise Behrends, Todd Bradley, Erin Hytrek, Brad Earp

BOARD MEMBERS ABSENT

Jaclyn Fleming, Jenifer Furness, Morris Blankespoor

STAFF PRESENT: Judy Manning, board administrator

PUBLIC COMMENT

No public comment

ADMINISTRATIVE RULES

Denise made a motion to adopt the changes to OT Chapters 206 and 209 that were noticed as ARC 0134C. Motion was seconded Brad. Motion carried unanimously.

FUTURE BOARD MEETINGS

September 28, 2012	June 21, 2013
December 21, 2012	September 13, 2013
March 15, 2013	December 20, 2013

ADJOURNMENT

Erin made a motion to adjourn the meeting at 7:05 am. Motion was seconded by Todd. Motion carried unanimously.

Respectfully submitted
Iowa Board of Physical and Occupational Therapy

Meeting Minutes
Iowa Board of Physical & Occupational Therapy
June 15, 2012
Lucas State Office Building, 5th Floor Conference Room #526
Des Moines, Iowa

Call to Order:

The meeting was called to order by Denise Behrends, Chair at 9:01am.

Roll Call:

Members Present:

Denise Behrends, OT; Bradley Earp, PT; Todd Bradley, PT; Jennifer Furness, OT; and Jaclyn Fleming, Public Member

Members Absent:

Morris Blankespoor, Public Member and Erin Hytrek, PT

Staff Present:

Judy Manning, Board Executive; Barb Christiansen, Administrative Assistant; September Lau, AAG; Barb Huey, Bureau Chief and Karla Hoover, Licensure Specialist

Guests Present:

Dennis Tibben, Iowa Medical Society

Election of Officers:

Denise Behrends was unanimously elected as Chairman.
Jennifer Furness was unanimously elected as Vice Chairman.

Review Agenda:

Approval of Minutes:

A motion was made by Fleming to approve the meeting minutes of March 16, 2012. A second was received from Bradley. All ayes, opposed none, motion carried.

Public Comment: No public comment was received.

Reports:

Board Executive: Judy Manning reported that FSBPT offered two PT exams this month and both were filled quickly. Applicants are having trouble finding a location close to their home to take the exam. There will be one PTA exam given later in July so not as big a problem in finding a spot to test. Judy asked members to update or correct the roster as needed.

Bureau Chief: Barb gave an update on the new software application.

Chair: No report.

AAG: Guidelines for Board Members 2012 review. September also reviewed cannons regarding hearings and sitting in a judicial role during a hearing by board members. Exparte communication was explained, if the members do have questions an administrative law judge will be available to the board. September went through the process of what happens during a hearing.

Administrative Rules:

Adopt changes to OT Chapters 206 and 209. Changes to the OT administrative rules were noticed and a public hearing was held. Judy will schedule a conference call on July 5th for adoption of these rules. Only received one comment during the public hearing and it was in support of the changes.

Changes to the Occupational Therapy law, Chapter 148B, will be effective July 1, 2012. Judy will provide board members with an unofficial copy of the new law.

New Business:

FSBPT Annual Meeting: FSBPT will fund 100% of travel expenses for 3 board members to attend this meeting. The annual meeting will be held in Indianapolis, IN September 20-22, 2012. Judy asked for members who are interested in attending. Brad Earp and Denise Behrends volunteered to attend the meeting. Judy will attend the Board Administrator track of the meeting.

NBCOT Annual Meeting: Meeting will be held in Alexandria, Virginia in October 2012. Jenifer Furness would like to attend the meeting. Registration fees will be covered by NBCOT all other expenses are the responsibility of state.

Motion was made by Earp to approve Merchant to re take the PTA exam. A second was received from Furness. All ayes, opposed none, motion carried.

Motion was made by Bradley to approve Mueller to retake the PT exam. A second was received from Earp. All ayes, opposed none, motion carried.

Motion was made by Furness to approve Johnson to re take the PTA exam. A second was received from Bradley. All ayes, opposed none, motion carried.

Complaints:

A motion was made by Fleming to enter into closed session at 9:37am to discuss confidential material related to complaints according to Iowa Code Chapter 21.5(1) d. A second was received from Bradley. Roll call taken: Furness – Aye; Behrends – Aye; Earp – Aye; Bradley – Aye; Fleming – Aye. Motion carried.

A motion was made and carried to return to open session at 10:05am.

Case #09-11 A motion was made by Furness to approve the Statement of Charges. A second was received from Earp. All ayes, opposed none, motion carried.

Case #11-010 – A motion was made by Earp to approve the settlement agreement. A second was received from Bradley. All ayes, opposed none, motion carried.

Case #11-012 – A motion was made by Bradley to approve Statement of Charges with date changes. A second was received from Furness. All ayes, opposed none, motion carried.

Case #12-001 – A motion was made by Earp to approve Statement of Charges. A second was received from Fleming. All ayes, opposed none, motion carried.

Future Board Meetings:

September 28, 2012	June 21, 2013
December 21, 2012	September 13, 2013
March 15, 2013	December 20, 2013

Adjournment:

A motion was made by Furness to adjourn the meeting at 10:08am. A second was received from Earp. All ayes, opposed none, motion carried.

**Iowa Board of Physical and Occupational Therapy
Board Meeting
March 16, 2012**

**Lucas State Office Building
5th Floor Board Room 526
Des Moines IA 50319**

MINUTES

CALL TO ORDER

The meeting was called to order at 9:04 a.m. by Chairperson, Denise Behrends.

MEMBERS PRESENT

Denise Behrends, OT; Erin Hytrek, PT; Bradley Earp, PT; Morris Blankespoor; and Jaclyn Fleming

MEMBERS ABSENT

Todd Bradley, PT and Jennifer Furness, OT

STAFF PRESENT:

Judy Manning, Board Executive; Barb Huey, Bureau Chief; September Lau, AAG; Karla Hoover, Licensure Specialist; and Barb Christiansen, Administrative Assistant

OTHERS PRESENT:

Dennis Tibben, Iowa Medical Society; and Peggy Parker, Iowa Occupational Therapy Association

Review Agenda:

The agenda was changed to allow for the discussion of the Administrative Rules immediately following Public Comment.

Approval of Minutes:

A motion was made by Hytrek to approve the minutes for the December 16, 2011 meeting and the January 10, 2012 conference call. Earp seconded the motion. All ayes, opposed none, motion carried.

Public Comment:

No public comment.

Administrative Rules:

Judy Manning presented the changes to the Occupational Therapy administrative rules, chapters 645—206 and 209. Members of the Iowa OT Association and a committee of board members met in February to finalize the rules changes. Judy asked about the onsite and insight supervision language and also discussed chapter 206.8(4) supervision of other unlicensed assistive personnel. Board gave consensus for the Notice of Intended Action to be filed. The

Notice will be posted on the website under the News and Events link. A public hearing will be scheduled and any comments received will be shared with the board at the next board meeting. Peggy Parker reported that the IOTA is supportive of changes that are being recommended.

Reports:

Board Executive: Judy Manning advised board members to contact Karla if they have any changes to the roster. Jaclyn Fleming has been reappointed to the board for another 3-year term. Mike Mandel, Executive Director of the Iowa Physical Therapy Association, is retiring in June 2012. Judy expressed her appreciation and thanks for the support and guidance that Mike has provided the Board and wishes him well in his retirement. NBCOT is accepting nominees for a vacant board of director's position. This is a 3-year term that begins 10/1/12. FSBPT fixed date testing dates have been finalized for the PT and PTA exam. July 2 and 31 are dates for the PT exam and April 26 is the first fixed date testing for PTA exam. Approximately 7,090 seats have been blocked and reserved for the PT exam and will be released 21 days prior to the exam date. 2013 test dates will be released later this year.

Bureau Chief: Barb Huey reported that the first Amanda folders include PT/OT and have started testing to make sure the folders are working as they need to. The "Board Meet" folder will provide every board member with a user ID to look at confidential information.

Chair: No Report

AAG: September Lau reported on legislative session activities.

Administrative Rules:

Changes to PT chapters 200 and 202 were noticed and a public hearing was held with no public comment received. These rules changes are now ready for adoption. A motion to adopt the rules was made by Fleming. A second was received from Hytrek. All ayes, opposed none, motion carried.

New Business:

E-mail from Shawn Murphy regarding IAC 645—200.6(4): Board discussed that participating in treatment is a billable unit. The PT needs to be able to defend the treatment they provide. Every 5 visit is direct billable treatment for the PT. Judy will respond to the e-mail.

Tim Schultz is requesting permission from the Board to take the exam after 3 failed attempts. Board agrees to allow the individual to test the fourth time. A motion was made by Earp to allow this individual a fourth exam attempt. A second was received from Fleming. All ayes, opposed none, motion carried.

Sarah Woodham is requesting permission from the Board to take exam again. Ms. Woodham completed an additional 55 hours of training and a 9 day course in Illinois to prepare for the test. A motion was received from Hytrek to allow Ms. Woodham to take the exam again. A second was received from Earp. All ayes, opposed none, motion carried.

Ashley Liddle is requesting permission from the Board to take the exam again. Ms. Liddle has completed a 55 hour course and an additional 9 day course in Illinois. A motion was made by Hytrek to allow Ms. Liddle to take the exam again. A second was received from Fleming. All ayes, opposed none, motion carried.

Complaints:

A motion was made by Behrends to go into closed session at 9:45am to discuss confidential material related to applications and complaints according to Iowa Code Chapter 21.5 (1) a and d. A second was received from Hytrek. Roll call vote: Erin Hytrek, aye; Morris Blankespoor, aye; Brad Earp, aye; Jaclyn Fleming, aye; Denise Behrends, aye. Motion Carried

A motion was made and seconded to return to open session at 10:45am. Motion Carried.

Follow-Up to closed session:

A motion was made by Behrends to close case #11-007. A second was received from Hytrek. All ayes, opposed none, motion carried.

A motion was made by Hytrek to close case #11-008. A second was received from Behrends. All ayes, opposed none, motion carried.

A motion was made by Earp to close case #11-009. A second was received from Blankespoor. All ayes, opposed none, motion carried.

A motion was made by Behrends to file a Statement of Charges against Case #11-010 as discussed in closed session. A second was received from Hytrek. All ayes, opposed none, motion carried.

A motion was made by Hytrek to close case #11-011. A second was received from Earp. All ayes, opposed none, motion carried.

A motion was made to Hytrek to close case #12-004. A second was received from Earp. All ayes, opposed none, motion carried.

A motion was made by Earp to close case #12-002. A second was received from Blankespoor. All ayes, opposed none, motion carried.

A motion was made by Hytrek to adjourn the meeting at 10:48am. A second was received from Fleming. All ayes, opposed none, motion carried.

Open Session Meeting Minutes
IOWA BOARD OF PHYSICAL THERAPY & OCCUPATIONAL THERAPY
December 16, 2011
Lucas State Office Building, 5th Floor Conference Room #526
Des Moines, Iowa

Call to Order:

The meeting was called to order at 9:06 am by Denise Behrends, Chairperson.

Roll Call:

Members Present: Todd Bradley, PT; Morris Blankespoor, Public Member; Bradley Earp, PT; Denise Behrends, OT; Jaclyn Fleming, Public Member; Erin Hytrek, PT

Members Absent: Jennifer Furness, OT

Staff Present: Judy Manning, Board Executive; Karla Hoover, Licensure Specialist; September Lau, AAG; Barb Christiansen, Administrative Assistant; Barb Huey, Bureau Chief

Public Present:

Heidi Goodman, IMS; Dennis Tibben, IMS; Peggy Parker, IOTA; Mary Echterling, IOTA; Threase Harms, IOTA; Jenny Schulte, IOTA; Kyle Frette, IOTA

Denise Behrends, Chairperson, asked that the agenda be amended and allow for public comment at the beginning of this meeting.

Public Comment:

The Iowa Medical Society (IMS) commented on a possible change to Iowa Code Chapter 148A to allow PT's to administer medications. The IMS does not have a problem with the act of administering but would recommend language for "administration of topical medications". A discussion followed regarding the administration of oxygen. The IMS suggested that Terry Witkowski with the Pharmacy Board be contacted for further clarification.

Peggy Parker, Iowa Occupational Therapy Association (IOTA) President, informed the Board that the recommended changes to Chapter 206 were provided to their membership for review and comment. The membership agreed that the current supervision rules for the OTA are very lax but they did not agree with the changes recommended by the Board. Since Iowa is a rural state this change could make a huge difference in how OT's supervise in the rural areas. The question was raised on the possibility of providing supervision by phone or on Skype to COTAs in rural settings. The Association also felt that there was not a clear definition of other assistive personnel. The association distributed a handout with comments received from members

regarding possible changes to Chapter 206. Denise Behrends suggested that the board work with the association and come to a mutual agreement on changes to the rules before the next meeting in March 2012.

Iowa Code 148B: This is primarily a cleanup of the Occupational Therapy code that will be introduced to the Legislature by the IOTA. The association has met with Representative Cownie and he has agreed to introduce a study bill in the house.

Administrative Rules:

PT rules for notice: The changes to Chapters 200 and 202 will revise the requirements for individuals that have failed the licensure exam more than three times; strike language that requires a bachelors degree to include of a minimum of 60 hours of general education and 60 hours of professional education since this is addressed under requirements for foreign-trained applicants; strike the requirements to send out a renewal notice by mail; and include language for conviction of a crime related to profession regardless of whether the judgment or conviction or sentence was deferred.

It was the consensus of the Board that the PT rules be noticed. A public hearing will be held January 31, 2012.

Chapter 12.6 Veterinary rules regarding animal physical therapy. Judy provided a draft of the changes the Veterinary Board is considering to address animal physical therapy. These changes were originally brought forward in 2001 but did not go forward at that time. The Board will track the Veterinary Board's decision on these changes.

Review Agenda:

Public Comment heard after roll call.

Approval of Minutes:

A motion was made by Bradley to approve the minutes from the September 16, 2011 meeting. A second was received from Earp. All ayes, opposed – none, motion carried.

Reports:

Board Executive – Judy Manning reported that she and Brad attended the FSBPT annual meeting in Charlotte, North Carolina in September. Some of the items discussed at the meeting included expunging discipline from a licensee's record after 15 years; a possible compact for PT licensure from state to state; PT temporary licensure (Iowa does not have code authority to issue a temporary license); and dry needling. APTA is completing a review of dry needling and will provide a report in 2012.

Department of Administrative Services has raised the lodging rate to \$82 + tax per night. This new reimbursement rate is effective January 1, 2012.

Bureau Chief: No report.

AAG: No report.

Erin Hytrek arrived at 10:05am.

New Business:

E-mail from Linda Coates: Questions about what constitutes a visit. Iowa enlists that every fourth visit a PT has to see the patient. When the patient is acute care they should be seen more often and a PT should be present. The question from Linda was that a rehabilitation company is trying to get more visits out of the PTA and less by the PT's. A visit is considered each time a patient is seen by the PTA as delegated by the PT. A visit is not a day it is a treatment session. Even if one note is written, if the patient is seen two times it is two visits.

Letter from Mary Ellen Hawkeye Community College: A group of 19 students will have to wait until January 2013 to take the exam because the Hawkeye Community College PTA program will not be CAPTE accredited until October, 2012. The Board's rules state the applicant for licensure must be a graduate of a CAPTE accredited program. September Lau, AAG, stated that the board's rules do not state the student may not take an exam, it does state however, that the student cannot be licensed until the completion of an accredited program. The board could grant a waiver to take the exam before the program is accredited. However the board will make it clear to the students that they will be allowed to take the exam but if the school is not granted the accreditation the students will not be able to get their license.

Individual has failed exam three times. The person does not have any additional course work to report. Student is currently being mentored by a PT and would like to have permission to re-take the exam. Board members agreed the student could go ahead and take the exam again.

Petition for Waiver:

Petition received from an individual who received her initial PT education in India requesting a waiver of the TOEFL requirement. Stated her Physical Therapy education was taught in English also the text book was in English as well as the transcript, however the program she took was not a CAPTE accredited physical therapy program. A motion was made by Hytrek to deny the Petition for Waiver. A second was received from Earp. All ayes, opposed – none, motion carried.

Individual asking for a waiver in regards to TOEFL score. Individual was very close to passing the exam and is asking the board to waive the required passing score to include her total score. Board discussed the issue of lowering the bar for scoring and the precedent it might set. Board stated she did not meet the minimum requirements of successfully passing the TOEFL exam. A motion was made by Hytrek to deny the waiver. A second was received from Earp. All ayes, opposed – none, motion carried.

Board took a 5 minute break before entering into closed session.

A motion was made by Bradley to enter into closed session at 11:00am. A second was received from Hytrek. Roll call was taken: Hytrek, aye; Bradley, aye; Fleming, aye; Behrends, aye; Blankespoor, aye; Earp, aye.

A motion was made and seconded to return to open session at 11:41am.

Follow-up on Closed Session

Unlicensed individual who is billing for PT services – fraudulent practice is alleged. Judy has attempted to contact the company with no response. Judy will send letter to company about the complaint and wait for response.

Case #10-005 - A motion was made by Hytrek to close case. A second was received from Bradley. Ayes – 5, opposed – none, abstain – 1, motion carried.

Case # 10-009 - A motion was made by Behrends to close case. A second was received from Hytrek. All ayes, opposed – none, motion carried.

Case #11-006 - A motion was made by Earp to close case. A second was received from Fleming. All ayes, opposed – none, motion carried.

Case #09-008 - A motion was made by Bradley to accept the order granting modification of the original Settlement Agreement issued to this individual. A second was received from Earp. All ayes, opposed – none, motion carried.

Case #11-002 – A motion was made by Fleming to accept the Settlement Agreement. A second was received from Hytrek. All ayes, opposed – none, motion carried.

Future Board meetings for 2012

March 16, 2012	September 28, 2012
June 15, 2012	December 21, 2012

A motion was made by Bradley to adjourn the meeting at 11:50 am. A second was received from Earp. All ayes, opposed – none, motion carried.

Functional Dry Needling® Level 1

Elevate your practice to a new level of patient care by entering this Functional Dry Needling® course of study which teaches the insertion of fine filament needles into neuromuscular junctions/motor points, stimulating the muscle, bringing unbelievable pain relief and significantly improved function to athletes and patients who have been suffering for years.

This 3-day course teaches the technique and involves ample lab time to test, practice and perfect the art and science of functional dry needling to offer this to your patients the very next day. Musculature taught in the introductory level involves areas of the hip, lower extremity, thigh, upper extremity, shoulder, lumbar spine and cervical spine. A strong emphasis on safety and precaution is reinforced, as well as clinical application, research, history of dry needling, and relevant case study.

Upon completion of this introductory level course, each practitioner will understand trigger points and the clinical presentation of neuromuscular dysfunction. They will demonstrate competency in dry needling of the muscles covered and will understand indications, contraindications, precautions and complications associated with Functional Dry Needling®. To earn this certificate, all practitioners must pass both a theoretical and practical examination.

Prerequisites include maintaining a current license as PT, MD, DO, DC, NP or PA with a minimum of one year practicing on the professional license. (Colorado PTs must practice for 2 years prior to taking the FDN course.) Please see our Course Materials tab for important guidelines and pre-reading materials that will prepare you for the course.

Course Registration Includes:

Water and Lunch is provided all 3 days. Please bring any additional snacks/drinks you would like in order to keep physically sustained throughout the weekend. Also note that we provide lunch for the three days, but we cannot offer food sensitive options. We are happy to assist you in locating meal options in the vicinity of the course venue.

Supplies to be used throughout the course (we offer small, medium and large sized gloves).

FREE NEEDLES to begin practicing the day after the course

A comprehensive full colored manual (200 pages)

A FREE 3 Months free trial Membership which will provide you with a Therapist Listing on our website for potential referrals. It also includes educational videos, marketing and documentation resources, and a communication forum to stay in touch with instructors and fellow FDN practitioners.

Continued support from KinetaCore®

Please Note: As this course includes extensive lab work, all course attendees should come prepared to participate as both clinician and simulated patient for the purposes of education. Because of the intense nature of this treatment, it is vital to your patient care that you have experienced this treatment in an educational setting.

Pregnant women may not participate in this course due to risks associated with the practical sessions! If you know you have become pregnant by the time your course begins, please notify us and we will allow you to re-enroll at a later date!

It is important that you come prepared to take this course and pass both theoretical and practical testing to earn your certification to practice dry needling. If you do not pass either Theory or Practical test, you will be required to re-take and re-test all material, which will incur further registration fees. Read, study and come prepared. Dry Needling Level 1

Course Agenda

Day One 8 am – 6 pm

7:30-8:00 Registration

8:00-8:30 Welcome! Course Introductions

8:30-9:00 Anatomy Exam

9:00-10:00 Introduction to Dry Needling:

History

Definitions and Terminology

Scope of Practice

Needle Safety

10:00-11:00 Lab Experience: Needle Orientation and Clean Needle Technique

11:00-12:30 Understanding Neuromuscular Dysfunction, Theoretical Constructs

12:30-1:00 Lunch

1:00-2:00 Exposure to Selective Functional Movement Assessment

Lab Experience: SFMA

2:00-3:30 Posterior Hip: Lecture and Lab

3:30-5:30 Anterior Hip and Thigh: Lecture and Lab

5:30-6:00 Aftercare Instructions, Questions, and Wrap-Up

Day Two 8 am – 6 pm

8:00-9:30 Understanding Pain

Physiologic Effects of Dry Needling

DN in Clinical Practice – The Functional Model

9:30-11:30 Lumbar Spine: Lecture and Lab

11:30-1:00 Cervical Spine: Lecture and Lab

1:00-1:30 Lunch

1:30-2:00 Whiteboard Questions/Discussion, Ordering Supplies

2:00-4:00 Shoulder: Lecture and Lab

4:00-5:00 Adductors: Lecture and Lab

5:00-5:30 Demonstration of Hamstrings

5:30-6:00 Supervised Practice of Practical Test Muscles

Day Three 8 am – 4 pm

8:00-9:00 Practical Testing, Theory Testing

Directed Lab Practice (Hamstrings, Repeat Posterior Hip)

9:00-11:00 Lower Extremity: Lecture and Lab

11:00-11:30 Whiteboard Questions/Discussion, Billing

11:30-12:00 Lunch & Website Presentation

12:00-2:00 Brachium and Antebrachium: Lecture and Lab

2:00-4:00 Clinical Integration and Wrap-up

**Agenda may be altered as needed for course flow

Analysis of Kinetacore FAQ

"What is Dry Needling?"

1. Very suspect that the site refers only "filament needle" when the truth is all filament needles used by DN are traditional acupuncture needles. The re-branding of an established medical device in order to avoid licensure rules is the major complaint of the Acupuncture profession.
2. Seeking out a "twitch" response is an very advanced acupuncture technique. The twitch response can happen spontaneously with novice acupuncture, but "Seeking out" refers to the rapid and vigorous thrusting of an acupuncture needle in and out of the muscle multiple times. In muscles of less than 2 inches in diameter (the majority of muscles), this thrusting can likely penetrate completely through the muscle into the organs or vessels underneath. In addition, muscle groups are infused with nerves and blood vessels. Thrusting in, out and through these anatomical structures is damaging not therapeutic. This advanced technique is taught in NCCAOM certified programs to advanced 3-4 year students having hundreds of hours of clinical observation and acupuncture practice. It is extremely dangerous to allow anyone with a few dozen hours of training to attempt this technique.

"What qualifications to take a DN course?"

1. "Professions that may participate...are those who have the ability, within their scope of practice, to puncture the skin and have extensive understanding of anatomy and palpation skills"

"Am I immediately able to use DN on patients after I complete the Level One course?"

1. Yes, after only a few hours spent practicing this advanced technique, the training programs allow/encourage the student to log in a minimum of 200 treatments prior to beginning Level 2.
2. In states that have set a minimum education hours, the training programs have intermediary seminars that fill in these hours.

"Will I be certified in DN once I complete the course?"

1. "you will receive a certificate of completion for each level.... This is not an accredited program through a University"
2. This lack of any national or professional accreditation organization is extremely disturbing. There are many programs teaching DN and none of them are accredited by a professional organization. In acupuncture as with most professions, the training programs are accredited by a national organization. This accreditation protects the students and the public from fraudulent programs and dangerous techniques.
3. The only NCCAOM accredited programs on Trigger point therapy are those who train experience Masters Degree level acupuncturists. The programs require completion of hundreds of hours of needling education prior to entry in the program.

"Supplies"

1. The website recommends "Seirin brand filament needles" In fact, Seirin is an excellent brand of Acupuncture Needles.
2. They mention that an average of 10-20 needles are used per patient session. If the normal process of Dry Needling is to stimulate a specific muscle group, then the practitioner might use 1-5 needles. If the session is using 10-20 needles, the protocols used are beyond Trigger Point therapy and are utilizing known acupuncture points, distal to the myofascial locations.

3. The sizes recommended, 0.30mm to 0.50mm diameter up to a length of 100mm are very large needles. The most common acupuncture needles are 0.16-0.20mm and a length of 30-50mm. The larger the needle, the easier it is to puncture deeper and the harder it is to feel the barriers of the muscle. A larger needle accidentally puncturing an organ, nerve or blood vessel is much more likely to cause significant damage. The DN programs teach the use of larger thicker needles because it requires hundreds of hours of clinical training in order to properly insert the safer thinner needles.
4. Certain DN courses train the use of "needle plungers". These devices hold an acupuncture needle in a spring-loaded chamber that allows the practitioner to quickly and forcefully insert the needle and thrust it up and down multiple times. The advertisement is that it is safer and allows the practitioner to use thinner needles without having them bend. Again, this shows the poor trained and unsafe needle technique being taught as Dry Needling. The truth is that any mechanical device with a spring will remove the control that is necessary to insert an acupuncture needle. This is extremely dangerous.

Title 10

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Subtitle 38 - BOARD OF PHYSICAL THERAPY EXAMINERS

10.38.12 Dry Needling

Authority: Health Occupations Article, §§13-101, 13-206, and 13-309, Annotated Code of Maryland

ALL NEW

.01 Scope

This chapter establishes standards for the provision of dry needling as a physical therapy intervention.

.02 Definitions

A. In this chapter, the following terms have the meanings indicated.

B. Terms Defined.

(1) "Board" means the State Board of Physical Therapy Examiners.

(2) "Dry needling" means a physical therapy intervention, also known as intramuscular manual therapy, that:

- (a) Involves the insertion of one or more solid needles, a type of mechanical device, into or through the skin to effect change in muscles and tissues for the purpose of alleviating identified impairments;
- (b) Requires constant evaluation, assessment, and re-evaluation of the impairments; and
- (c) Is not performed for the purposes of detoxification, smoking cessation, or stress relief.

.03 Education and Training Necessary to Perform Dry Needling

A. In order to perform dry needling, a physical therapist shall have at least 230 total hours of instruction to include:

(1) At least 100 hours of instruction in the following areas:

- (a) Surface anatomy;
- (b) Musculoskeletal system;
- (c) Skeletal muscle physiology;
- (d) Anatomical basis of pain mechanisms, myofascial pain, referred pain, and chronic pain;
- (e) Trigger points; and
- (f) Infection control, the Occupational Safety and Health Administration's Bloodborne Pathogen Protocol, and safe handling of needles;

(2) At least 80 hours of instruction in the following dry needling-specific course content areas:

- (a) Theory and application of dry needling;
- (b) Dry needling technique, including spine and extremities;
- (c) Dry needling indications and contraindications; and
- (d) Documentation of dry needling; and

(3) At least 50 hours of practical, hands-on instruction in dry needling under the supervision of a licensed healthcare practitioner competent in dry needling procedures who has completed the requisite coursework.

B. The instruction in dry needling-specific course content areas shall include an assessment of competency.

C. All dry needling-specific instruction under this regulation shall involve contemporaneous, face-to-face interaction between the physical therapist and the instructor in real time.

D. A physical therapist may not fulfill any portion of the practical, hands-on instruction required under §A(3) of this regulation with online or distance learning.

E. A physical therapist shall have practiced physical therapy for at least 2 years before the provision of dry needling in the State.

F. Upon request of the Board, a physical therapist practicing dry needling shall provide documentation that substantiates appropriate training as required by this regulation.

.04 Standards of Practice in Performing Dry Needling

A. A physical therapist shall:

- (1) Explain dry needling to the patient in advance of treatment; and
- (2) Obtain written informed consent that will be included in the medical record.

B. A physical therapist shall perform dry needling in a manner consistent with standards set forth in the Maryland Occupational Safety and Health Act, Labor and Employment Article, Title 5, Annotated Code of Maryland.

C. A physical therapist shall document the provision of dry needling services in accordance with the documentation requirements of COMAR 10.38.03.02-1.

D. Dry needling is not within the scope of practice of limited physical therapy and shall only be performed by a licensed physical therapist.

END NEW

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6
7 SUPERIOR COURT FOR THE STATE OF WASHINGTON
COUNTY OF KING
8

9 STATE OF WASHINGTON *ex rel.*
10 SOUTH SOUND ACUPUNCTURE
ASSOCIATION, a State of
11 Washington non-profit corporation,

12 Plaintiff,

13 vs.

14 KINETACORE, a Colorado LLC doing
business in the State of Washington; EDO
15 ZYLSTRA, CEO and owner of
Kinetacore; KERI MAYWHORT, a
16 Kinetacore instructor; EMERALD
CITY PHYSICAL THERAPY
17 SERVICES LLC doing business as
SALMON BAY PHYSICAL THERAPY
18 LLC, a limited liability company; JOHN
DOES 1-10; and JANE DOES 1-10.
19

ORIGINAL

NO. 13-2-04894-9 SEA

ORDER FOR PARTIAL SUMMARY
JUDGMENT

20
21 This matter came before the Court upon Plaintiff's Motion for Partial Summary
22 Judgment and Defendants Motion for Summary Judgment which the parties argued before the
23 Court on October 10th, 2014.

24 The Court has reviewed and considered the following:

25 1. Plaintiff's Motion for Partial Summary Judgment, and the declarations from Brent
ORDER GRANTING PARTIAL SUMMARY
JUDGMENT - 1

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- 1 Foster and Daniel Dingle and all supporting exhibits;
- 2 2. Defendants' Motion for Summary Judgment and supporting declarations and
- 3 exhibits;
- 4 3. Plaintiffs Response to Defendants' Motion for Summary Judgment and supporting
- 5 declarations and exhibits;
- 6 4. Defendants Response to Plaintiff's Motion for Partial Summary Judgment and
- 7 supporting declarations and exhibits;
- 8 5. Plaintiffs Reply to Defendants' Response to Plaintiffs' Motion for Partial Summary
- 9 Judgment and supporting declarations and exhibits;
- 10 6. Defendants Reply to Plaintiff's Response to Plaintiffs' Motion for Partial Summary
- 11 Judgment and supporting declarations and exhibits;
- 12 7. The parties' oral arguments before the court;

13 Based on the foregoing, and after consideration of the standard in Civil Rule 56,
14 NOW THEREFORE IT IS HEREBY ORDERED that Plaintiff's Motion for Partial Summary
15 Judgment is GRANTED and Defendants Motion for Summary Judgment is DENIED. It is
16 further declared that:

17 A. A person that "penetrates the tissues of human beings" with an acupuncture
18 needle or any other needle for purpose of "dry needling" or any similar named
19 act ("dry needling") is practicing medicine under the statutory definition
20 provided at RCW § 18.71.011(3) and is prohibited absent a physicians license
21 as required by RCW § 18.71.021; *or other statutory authority;*

22 B. ~~There is no factual dispute that defendants are not licensed physicians but have~~
23 ~~penetrated the tissues of human beings with acupuncture needles during the~~
24 ~~Kinetacore workshop and subsequent to the workshop and describe such acts as~~

25 ORDER GRANTING PARTIAL SUMMARY
JUDGMENT - 2

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1 “dry needling;”

2 C. The penetration of human tissue with an acupuncture needle or any similar needle
3 used for dry needling is outside the plain text of the authorized scope of practice
4 for physical therapy as adopted by the Washington Legislature in RCW §
5 18.74.010(8);

6 D. The plain text of the physical therapy statute, applicable case law, and the
7 legislative history of RCW § 18.74.010(8) each support that there was no
8 legislative intent to authorize physical therapists to insert acupuncture needles
9 into human tissue for the purpose of dry needling or any similar purpose;

10 E. As such, physical therapists are not exempt from the requirement for a
11 physicians license pursuant to RCW § 18.71.030(4) prior to the penetration of
12 human tissue with acupuncture needles or similar needles.

13 F. Unless otherwise specifically authorized to practice acupuncture under another
14 professional licensures, such as a physician or practitioner of East Asian
15 Medicine, a licensed physical therapists lacks the legal authority to penetrate
16 human tissue with acupuncture needles, or any similar needle, for the purpose
17 of dry needling. Such act constitutes the unauthorized practice of medicine
18 which is prohibited under Washington statute. RCW § 18.71.021; RCW §
19 18.71.011(3).

20
21
22 It is further declared that:

23 6. Defendants are hereby enjoined from inserting acupuncture needles or any similar
24 needles for the purpose of dry needling in the State of Washington;

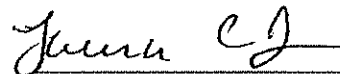
25 ORDER GRANTING PARTIAL SUMMARY
JUDGMENT - 3

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1 H. Defendant Kinetacore is hereby enjoined from holding any workshops, classes or
2 similar trainings in the State of Washington that involve ^{conducting} ~~any~~ penetration of human
3 tissue with acupuncture needles or similar needles by physical therapists that lack
4 the legal authority to penetrate human tissue pursuant to the findings above.

5 E. _____
6 _____
7 _____
8 _____

9
10 Dated this 10 day of October, 2014.

11
12
13 

14 _____
15 C. Inveen The Honorable Laura

16 Presented by:

17 **CRANE DUNHAM PLLC**

18 s/ Jason T. Leehan

19 s/Stephen J. Crane

20 WSBA No. 42463

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LAW OFFICES OF BRENT FOSTER

s/ Brent Foster, Pro Hac Vice

Oregon Bar No. 99263

Attorneys for Plaintiff

ORDER GRANTING PARTIAL SUMMARY
JUDGMENT - 4

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